Modernising workforce data collection in social care

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Modernising Workforce Data Collection in Social Care

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LIST OF TABLES AND FIGURES

GLOSSARY OF TERMS

ADASS	Association of Directors of Adult Social Services
ADCSS	Association of Directors of Children's Social Services
ADSS	Association of Directors of Social Services
CQC	Care Quality Commission
CSCI	Commission for Social Care Inspection (formerly the NCSC)
DCSF	Department for Children, Schools and Families
DfES	Department for Education and Skills
DH	Department of Health
EO	Employers' Organisation
FAQ	Frequently Asked Questions
GSCC	General Social Care Council
HPC	Health Professions Council
IDEA	Local government Improvement and Development Agency
IiP	Investors in People
InLAWS	Integrated Local Area Workforce Strategy
ITN	Invitation to Negotiate
ITT	Invitation to Tender
KCL	King's College London
LAs	Local Authorities
LAWIG	Local Authority Workforce Intelligence Group
LeaRNS	Learning Resource Network
LGA	Local Government Association
LGAR	Local Government Analysis & Research
LGE	Local Government Employers
LSC	Learning and Skills Council
NAAPS	National Association of Adult Placements
NCSC	National Care Standards Commission
NHS	National Health Service
NINo	National Insurance Number
NMDS-SC	National Minimum Data Set-Social Care
NWIP	National Workforce Information Programme
OJEU	Official Journal of the European Union
PAs	Personal Assistants
PQQ	Pre-qualification Questionnaire
PWC	Price Waterhouse Cooper
RDA	Regional Development Agency
RDM	Regional Development Manager
RDO	Regional Development Officers
RNHA	Registered Nursing Home Association
SC&HWFG	Social Care and Health Workforce Group
SCWRU	Social Care Workforce Research Unit
SfC	Skills for Care
SMT	Senior Management Team

SRI	Skills Research and Intelligence
TOPSS	Originally called Training Organisation for Social Services - changed to the initials alone in 2002
Topss England	A derivative of TOPSS above – standing for nothing
TOR	Terms of Reference
TSI	Training Support Implementation funding
WDC	Workforce Development Confederation
WFI	Workforce Intelligence
WFIG	Workforce Intelligence Group
WILGUK	Workforce Liaison Group United Kingdom
WONAB	Workforce Numbers Advisory Board

ABSTRACT

Modernising Workforce Data Collection in Social Care: rationalising, systematising and modernising the process of collecting and subsequent use of data on the workforce of the social care industry in England.

Overview
This is a study of a key development in workforce data collection and the development of workforce intelligence in social care in England.

Aims
To investigate the establishment of the National Minimum Data Set for Social Care (NMDS-SC) in England 2003-2010.
To consider the establishment of the NMDS-SC in the light of the size of and disparate numbers of employers in the social care sector, and the legal, policy and service delivery context.
To consider the role of data sets in workforce planning and requirements in social care and to explore the importance of stakeholders in the development of the NMDS-SC.

Literature
The study reviews the literature about social care workforce data sets and sets it in its theoretical context. The background to the study is presented with considerations of quantitative and qualitative analyses of workforce intelligence in social care in England: the role of key organisations in data collection such as Topss/Skills for Care England, Government Departments, The Employers Organisation, the National Care Standards Commission and its successor, and the Sector Skills Council for social care, Skills for Care.

Methods
This study uses a case study approach and draws on material that is publicly available. It describes and analyses the introduction of the NMDS-SC. It uses insights from stakeholder theory, complexity theory, and the use of marketing and draws on insights from the management of change. It explores how and why the process of rationalising, systematising and modernising the process of data collection about its workforce by the English social care industry took place in the years 2003-2010.

Findings
Findings centre on the description of and reflection on the process of implementation. There are descriptions of the different stages of development of a national data set. Risk assessment and management emerge as key themes.

Discussion
The thesis moves to analyse and discuss the findings in light of the literature and theoretical perspectives.

Conclusion and Recommendations
The thesis concludes with a series of recommendations for the future of NMDS-SC and for the better understanding of data collection in social care.

DECLARATION
I declare that no portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.

Francis Ward

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Date

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This thesis, and the significant effort put into knowing more about the social care workforce, are dedicated to the thousands of social care workers who day after day bring comfort and support to millions of individuals and do it all too often without any true recognition (and scant pay) from society.

CHAPTER 1: INTRODUCTION

This chapter explains the significance of social care workforce data and why they needed to be collected and scrutinised.

Background to the Study

Professionals and others working in the social care sector in England have long lamented the lack of good information about the social care workforce (Behan, 2008; Hussein, 2009b). This thesis was motivated by the need to rectify this situation. It tells the story of a piece of work designed to improve workforce data collection and sets this within the academic and critical framework of a case study approach towards developing a routine system for collecting workforce information. My aim was to devise a system of gathering information that the sector would find useful. This work was done with a view to increasing understanding of the workforce, so that it would be possible to map the social care sector in England. I wanted to raise the importance of this information, both within the sector and outside it. I knew that only when an accurate picture of contemporary social care could be captured, did society stand any chance of having its social care needs being efficiently and fully met in the future. The social care sector had never had a comprehensive measure of its workforce. I had one in mind.

Covey (2004) describes what he terms *The Seven Habits of Highly Effective People*: and adds a follow up, *The 8th Habit* (Covey, 2005) which appears to fit the work I embarked upon and which I describe in this thesis. Covey describes

the Habits as the intersection between Knowledge, Skill and Desire: the what, the how and the want to do. Briefly summarised, The Habits are:

1. Being proactive.

2. Starting with the end in mind.

3. Putting first things first.

4. Thinking win/win.

5. Understanding and being understood.

6. Synergising (using all the others together).

7. Taking the time to sharpen the saw; and

8. The need to find your voice and to inspire others.

(Covey, 2005: p.27)

During the course of this research, I developed my own confidence and gained that of others. My activities were informed by the work of Phillips (2003) on 'future basing', which encourages envisaging the ideal future and then endeavouring to establish which tools are needed to arrive there. From this I learned that it is important to link a clear understanding of what you expect at the end of a task with what is at the front of your mind throughout. I also understood the concept of taking 'massive action' at the point of making a decision, rather than tinkering with something after the event, which is argued to be part of achieving substantial change (Robbins & McClendon, 1997).

From childhood I recalled the quote from Lewis Carroll's *Through the Looking Glass:*

> *"There is no use trying," said Alice; "One can't believe impossible things." "I dare say you haven't had much practice," said the Queen. "When I was your age, I always did it for half an hour a day. Why, sometimes I've believed as many as six impossible things before breakfast."*
>
> (Carroll, 1871: p.38)

Shortly before I started this thesis, the American politician Donald Rumsfeld said something that has been frequently quoted and seen by some as a little comical. For me, he could have been talking about the social care sector's knowledge of its workforce:

> *...there are known knowns. There are things we know that we know. There are known unknowns. That is to say there are things that we now know we don't know. But there are also unknown unknowns. There are things we do not know we don't know.*
>
> (Rumsfeld, 2002: p.1)

Over my working life I have acquired a good knowledge of workforce planning and the need to strategically plan the use of resources. My understanding was reinforced by a belief in my ability to persuade the sector that radical change was the only way to achieve any significant difference; a difference that would be worth the effort and beneficial over time. This is the story of a seven year mission that has at times been difficult and challenging, and at others rewarding and exhilarating. In this chapter, I outline the plan of this thesis, analysing the

story in the chapters ahead. My first scribbles of a mind map (Appendix 1) became my original proposal to undertake a PhD (Appendix 2).

My approach to this thesis is not a conventional social science approach because I was employed to implement a solution. I had an idea while collecting information towards the end of 2002 for my work. I enquired at King's College London and, in November 2003, embarked on PhD studies in parallel with my paid employment. For me the key thing was the inexorability of both tasks of work and study through the process using an action research case study approach. I later discovered this has been called 'mechanistic-oriented action research' leading to pragmatic outcomes (Coghlan, 2003).

I shall further set the scene, in this opening chapter, by discussing the problems and complexity of adult social care and its workforce in England. I will outline the evidence from research and other sources which existed in 2004. I will also describe more recent debates about the possible future workforce and the demands that might be made on it in the years ahead. I will discuss the challenges of making the social care sector more efficient, and some of the earlier attempts made to measure and understand the sector and its workforce. This thesis details the work done and methodology used to achieve a major development in gaining better workforce data for the social care industry and the United Kingdom (UK) government by developing the National Minimum Data Set for Social Care (NMDS-SC), and the related structure needed to collect such information. In the future, structured and planned methods to raise the

profile and enhance the skills of this workforce should no longer have to be built on a weak evidence base.

This picture of a lack of workforce data does not overlook pockets of influential and careful research. However, despite interest and a body of committed researchers across the country, the social care sector has lacked reliable sets of data. Establishing an agreed data set covering this workforce and encouraging people to contribute to it would address this absence and help the sector and researchers alike. In hindsight, establishing a data set was not an easy or simple task, as will be described below in my discussion of the policy and demographic context.

Workforce Data - Early Collection

Prior to 2000 I had tried to gather what was known about the social care workforce, when contributing to the first Training Strategy for Topss England in 1999. Topss England was established in 1999 as the Training Organisation for Personal Social Service, known from 2002 onwards simply as Topss. On April 1st 2005 Topss England became Skills for Care, and the role of collecting world-class data for social care became its main strategic objective in its position as the Sector Skills Council for adult social care in England. My interest in this subject had begun in 2002. I started collecting as many of the numerous but separate reports and analyses on the workforce in social care in England as I could locate. Some were glossy and attractive, written by many multiple authors, in regions and sub-regions commissioned by local, regional and occasionally national stakeholders. These included Regional Development

Agencies and some NHS Confederations. I naively thought it would be a straightforward task to compile a synopsis of their data and findings. Things proved very different, as will be covered below.

In 2003 I commissioned the first report covering the social care sector's workforce for the Training Organisation for Personal Social Services (TOPSS), entitled *The State of the Social Care Workforce* (Eborall, 2003). This was intended to be the first of a series of annual reports, and was followed in 2005 by a second report (Eborall, 2005). The author, Christine Eborall, had compiled a series of the Central Office for Information (COI) reports for the Department of Health in 2001 (Eborall & Gamerson, 2001) and later joined Skills for Care in 2005 having previously been commissioned to write the first *State of the Social Care Workforce* report in 2003.

Eborall's early reports and her later work form the evidence base about the social care workforce as referenced by researchers and policy makers. They have proven especially useful as background material to the work of Hussein, who has recently been producing a series of Social Care Workforce Periodicals (vol. 1-16) published as secondary analysis of the NMDS-SC data (see Chapter 3).

Eborall's early reports gathered existing data on the workforce in England and revealed, for the first time, the limits in national knowledge of the sector's workforce. Annual updates proved too great a task. However, a third report was

issued in 2008 (Eborall & Griffiths, 2008) and a fourth in 2010 (Eborall et al., 2010).

Late in 2003, I proposed the concept of an agreed national sector minimum data set to my managers at Skills for Care, as a potential solution to poor social care workforce information. If this data set could be systematised, it could operate universally as an electronic system in England's social care sector to collect data on its workforce (see Appendix 2).

Trying to collect workforce data in 2002 proved to be a much harder task than I could have envisaged. At this point, my job had focused on the learning disability workforce in social care, with a remit to try to gain an understanding of its size and characteristics. This was completed in a simplistic fashion, but the lack of quality information available exposed how little Topss knew about the social care workforce as a whole.

Policy Context

In this section I explore why the social care workforce is important and to whom. The purpose of this is to explain the sector and outline why it is often ignored.

An Expert Seminar held at King's College London in 2003 set out the main reasons to seek greater understanding of the social care workforce. The opening paragraph of its report said:

> *In contrast to the NHS workforce, the quantity and quality of intelligence about the social care workforce are poor. Relatively little primary research*

> *is being undertaken on the topic and, although there are many (and growing) relevant information sources, there is no national 'map' of what data are being collected, where or how. The overall purpose of the seminar was to identify the existing evidence on the social care workforce, both research and information-system based, assess its coherence and comprehensiveness and identify what new evidence is needed.*
>
> (Social Care Workforce Research Unit, 2003: p.3)

The growing cost of long-term care for the increasing numbers of older people and some disabled people has become an issue that successive governments have attempted to address. However, it was not until recently that the then Labour government produced the first policy documents about the social care sector's workforce, *Putting People First* (DH, 2007b) and *Shaping the Future of Care Together* (DH, 2009b).

Nonetheless, social care is increasingly recognised as an important part of public services in British society, and the industry's workforce is its main resource because of the labour-intensive nature of social care. Britain already has a large population of older people, and the oldest old are growing in number particularly (European Commission, 2007; Costa-i-Font et al., 2008; Wittenberg et al., 2008b; Office for National Statistics, 2009a). The need for care among this later age group is predicted to rise.

The Office of National Statistics (2009a), the Wanless Report (2006) and the Department of Health's green paper (2009b), allude to the rising expense of social care.. It has been established that significant investment in this workforce

is needed to ensure quality services (Eborall et al., 2010). Understanding the social care workforce may mean the workforce is used more efficiently, that it acquires improved resources and that social care work itself has a higher profile and significance within society. With a major downturn in the world economy, following the banking crisis, resources for publicly funded social care are likely to get even scarcer. The Coalition government of 2010 has made budget cuts that will have a significant effect on public sector spending. In July 2010, Phillip Hammond, the then Transport Secretary, said that departments had been told to go through their budgets 'line by line' to find savings of between 25- 40 percent (BBC Online, 2010), comments which were soon outlined in the Comprehensive Spending Review (HM Treasury, 2010). Developing a better understanding of the workforce and its activities may help make resource allocation more efficient or reductions less harmful.

Limitations of this Study

The objective of the first part of the Wanless Report was to examine the "*demographic, economic, social, health, and other relevant trends over the next 20 years that are likely to affect the demand for and nature of social care for older people (aged 65 and over) in England*" (Wanless, 2006: p.12). Wanless re-affirmed that social care is labour intensive. He argued that ensuring the availability of a good quality workforce is essential, whichever model of social care is chosen by society. He estimated that in 2003-4, the English workforce supporting older people alone was in excess of 779,000 employees. At the time, Eborall argued this was an underestimate. In her estimates, which were based

upon a combination of data from Labour Force Surveys, Local Authority returns, Industry surveys and information provided by regulators, she concluded that:

> *922,000 people are in paid employment in core areas of social care, defined as including social work, residential, day and domiciliary care staff in all sectors, agency staff and a limited number of NHS staff, of whom some two thirds work with older people.*
>
> (Eborall, 2005: p.6)

The main information on the social care workforce in England had long been collected though the Employer's Organisation SSDS001 annual returns (established in the 1980s). These were sent to all the Local Authorities (LAs) in England with social service responsibilities (152 at the time of writing, 2012). Information on staffing was required by the Department of Health and the survey had to be undertaken by 30th September each year. Other information on the workforce had been included in the Delivery Improvement Statements (DIS) sent by LAs to the DH. These failed to produce comprehensive data because they covered so little and were so varied. Naturally, this only covered the statutory sector, a declining proportion of the total employers in social care.

This incompleteness spurred me to develop partnerships with sector stakeholders and to take on the responsibility for improving data collection and analysis for the sector, under the umbrella of its Sector Skills Council.

Data Challenges - Why the NMDS-SC was Needed

Attempts were made to gather consistent and complete data about this sector's workforce. For example, as mentioned in the previous section, the Employer's

Organisation collected some information from its annual survey of LA social service departments (see Chapter 2). Where cross-sector (i.e. health, social or education) approaches had been attempted, they achieved a poor response rate and consequently had very little to offer to any comprehensive analysis of this workforce. Different sectors used different terminology and had access to different information, making it difficult to analyse them collectively. Examples of these were regional LSC, RDA and NHS Consortia reports of 2000-2004.

The social care sector in England is now characterised by a diversity and multitude of employers, job roles and methods of working, reaching two million service users and including over 30,000 small business provider establishments (Eborall et al., 2010). Chapter 5 discusses the particular difficulties of counting this workforce. In summary, these difficulties largely stem from the move to private provision within social care.

The provision of social care in England - and increasingly, across Europe - is moving from public to private and voluntary sector provision (Pavolini & Ranci, 2008; Frangakis et al., 2009). In the UK government policy has restricted LAs as providers (NHS and Community Care Act 1990), insisting upon use of the independent sector. This shifted LAs from being the main employer in the sector to a largely commissioning role.

Five years ago, the DH estimated that LAs in England employed around one third (32%) of the social care workforce (DH, 2005: p.8). More recently Eborall et al. (2010) estimate that this has fallen to less than 13 percent: 197,000 of the

total 1.61 million directly employed workers. Less than 8 percent of care homes and 12 percent of domiciliary or home care providers were being operated by LAs In 2010.

The resultant problems of planning and knowing the diverse nature of this sectors workforce were pithily summarised by Eborall:

> *Inadequacies in this area remain a fundamental problem. Data are not comprehensive; they are uncoordinated; quality is very variable indeed; formats often prevent interesting linkages; return rates from some sectors are so low that no useful conclusions can be drawn from them. It is also the case that much is collected and never used, and that often only the most primitive analytic techniques are applied to the data. Sophisticated statistical techniques for replacing missing data are conspicuous by their absence.*
>
> (Eborall, 2005: p.11)

Demographic Change and its Impact on Social Care Policy

As Wanless (2006) summarised, people in England are living longer, and over the next 20 years, the size of the population aged over 85 years will grow by two thirds, compared with a 10 percent growth in the rest of the population in England. The evidence base for this is expanded on by Wittenberg et al. (2008b), Comas-Herrera et al. (2007) and the Office for National Statistics (2009a).

Social care aims to protect vulnerable individuals from harm and 'plays a key role in maintaining a stable and cohesive society' (DH, 2005: p.6). The workforce is significant both in size and as a proportion of the overall

workforce in England, and accounts for around 80 percent of expenditure on social care (DH, 2004). As the DH stated, 'the critical role of staff in the social care process has long been recognized' (DH, 2007b); but recruitment to this workforce can be a problem.

In parallel, a fresh policy emphasis on personalised services promoting 'Independence, well-being and choice', initially through *Options for Excellence* (DH, 2006a) and the White Paper *Our health, our care, our say* (DH, 2006b)**;** and more recently under the new Coalition government, in *A vision for adult social care: Capable communities and active citizens* (DH, 2010b), has continued to move the focus of social care from residential models to one that will enable more people to be supported in their own homes. Such a scenario does not diminish the need for a social care workforce**;** it merely shifts its location from care homes and building**-**based services, to home and community settings. It has been evident from the increase of private sector interest investment that social care as a sector is becoming more business-like, with larger companies taking an interest in its potential profit margins. The social care workforce is in constant demand (Lethbridge, 2005a).

The wider social care workforce was estimated by Eborall (2005) at 1.6 million, including those working in childcare and early years, additional NHS staff with caring roles, foster carers and adopters, and some school staff. Later data narrowing this scope suggested over 1.39 million people are in paid employment in social care in England (Eborall & Griffiths, 2008: p.8) however, this was then revised to 1.61 million (Eborall et al., 2010).

One problem in estimates is that how the social care sector is constructed depends largely on what model of social care is being used. Does it include children and adults services? Should it include volunteers and family carers? There are several interfaces, such as those of the NHS and housing providers, where social care work is carried out in other sectors. Manthorpe and Moriarty (2011) have recently pointed to overlap within extra care housing where it is hard to differentiate care and housing support staff. Whatever definition of social care is used, recruitment costs and higher wage bills (although the increase is minimal in many cases), along with the costs of meeting regulatory demands to raise standards, look set to sustain and grow the sector and its workforce. The green paper *Putting People First* (DH, 2007b), acknowledged the benefits of improved data collection. It also pointed to the potential for LAs to develop their knowledge of the social care workforce in their locality through a Integrated Local Area Workforce Strategy (InLAWS), supported by Skills for Care and the DH (DH, 2007b; Skills for Care, 2009a and b). However, as the emerging Skills for Care briefings on the workforce (Skills for Care, 2007b) indicated, the public profile of social care remains low in comparison to the NHS (Cole, 2007) and these debates are sometimes confined within the sector. The next section outlines the preliminary steps to conceptualising a single comprehensive database.

Investigating Workforce Issues in Social Care

Irrespective of how society decides it wants its social care to be provided, the workforce and the efficiency with which it is managed are critical. Difficult

questions about the type and frequency of care, as well as who is eligible for care, are all compounded by the nature of the care and who is providing it. Wherever social care is situated, perhaps especially if there is a light touch from government or inspection, provision is often variable and sometimes problematic (CSCI, 2009). The private sector has invested in social care increasingly over recent years and can make high profits from consistent demand and a stable workforce, while the service user may get better quality services and greater consistency from a permanent, regular staff team. A small improvement in efficiency may result in large savings for local authority budgets, since they are the commissioners of most social care (Gershon, 2004).

Equally, a better-trained, more efficient social care workforce could present savings to individuals spending their own money or that of their family. Meeting their employment obligations, recruitment and retention issues - how to keep employees, once trained, and how to replace those you lose - are employers' primary concerns (Skills for Care, 2007b). Regulation has been further extended to employment practices in social care. Employers need to show inspectors how they manage their workforces. As this thesis goes on to describe, the Commission for Social Care Inspection (CSCI) – now the Care Quality Commission (CQC) – requires employers to complete workforce information based on the NMDS-SC in their annual return (since 2009).

Nonetheless, the importance of this data at an aggregate level is not always recognised. The quest for better information on this large workforce has potential benefits for all with an interest in social care, but was not mentioned

in any of the first Regional Development Agency (RDA) documents on the nature of the regional labour markets published in the late 1990s. Some RDAs later recognised that social care employment comprises between 4-8% of the workforce (Eborall, 2005) and is therefore a sizable sector.

In 2004, Topss England stopped its regional offices developing their own means of data collection and data demands, to avoid different regional approaches becoming entrenched. However, all Topss regions were faced with information demands, with no funding to support any centralised approach to data collection on the workforce. Complex funding from many stakeholders, who often had local and regional interests in gathering data on the social care workforce, seemed difficult to aggregate. Understandably, when developing the work outlined above, the issue of funding was not addressed with any degree of sophistication. In part this was because there were no models for cost-estimate processes. It was not possible for Topss England to present a business plan for data collection until the proposal for a centralised system (which came to be known as the National Minimum Data Set for Social Care - or NMDS-SC) was developed and agreed. Interestingly, Topss England made a brave attempt in its first training strategy to get service providers to train their staff, suggesting they contribute a percentage of their turnover to training on a *per capita* basis. This never transpired (Community Care, 1999) and, as will be seen later, the issue of training became entwined with that of data collection.

The Purpose of the Work

I undertook the development of a central data collection system for the social care workforce in England because I knew that the data on the social care workforce in England were inadequate. I believed I could find a solution to improve both the quality and the quantity of this data. It was necessary to demonstrate the potential benefits to care providers (employers), funders and users (of social care but also data). It became apparent early on that more data than anticipated were available covering the English social care workforce but these were limited and variable, as Chapter 2 outlines.

At the same time, there began to be greater appreciation of wider evidence about causal relationships between those employers who operate good human resource management and those who use this to undertake better workforce planning. As Cohen and Prusak (2001) stated, good employers are likely to have better trained (investment in human capital) and supported staff; and, consequently, staff in these organisations tend to be happier (Cohen & Prusak, 2001: p.153). They suggested that good employers have better abilities to retain staff (ibid: p.141). This is not a new concept among good employers who want a stable workforce that will keep working hard for them. Some Victorian entrepreneurs and conscientious employers built better housing and improved social conditions for their staff – such as Robert Owen and Joseph Rowntree, who recognised the importance of knowing and supporting their workforce (Burnett, 1978).

Skills for Care estimated that the social care industry spends £78 million on recruitment costs to replace the staff it loses each year (Skills for Care, 2007b). Money spent on recruitment is wasted if the industry does not have an understanding of who staff are and where they are most successfully recruited. Employers need to find ways they can keep the staff they want, so that they spend less time and resources recruiting (Skills for Care, 2007b). Those known as good employers are likely to have personalised training plans in place for their staff, as required by the CSCI. They may also have Investors in People status, or be working towards it (Eborall, 2005). They may also have better funding in place to deliver what is likely to be a good standard of service (ibid.).

Developing Strategies

In Chapter 5, I outline the development of the NMDS-SC. This section briefly reports the organisational background and the timing of the introduction of the NMDS-SC.

This work had a chronology and I have divided it into three phases, as listed below:

1. The preparatory groundwork of getting support from strategic organisations such as the DH.
2. The task of gaining the full support of the Skills for Care board.
3. The development of levers and incentives required to achieve compliance from employers.

Even if a system was successfully built, there was still the challenge of getting people to give their information. Our options were to offer incentives, through financial support (discussed in Chapter 5) and/or gaining their compliance through improved bureaucratic efficiencies; promises of less form filling in the future. It was always highly unlikely the DH would make it mandatory and even less that they would devise punishment for non-compliance. Policy change and the growth of personalisation are discussed further in Chapter 2.

The Skills for Care board acceded to my requests to develop the NMDS-SC and provided a powerful incentive for it to succeed by linking the allocation of funding of the Training Support Initiative (TSI), money from the DH (distributed via Skills for Care to employers), to the completion of data returns. Another incentive proposed was to require LAs to encourage completion of data in the commissioning of services. In 2006, this was recommended to social services departments by the Association of Directors of Adult Social Services (ADASS) Workforce Committee. In 2009, InLAWS developments continued to raise the importance of the link between the way LAs commission services and what they know about the employers and their workforce management (discussed further in Chapters 5 and 8).

Additionally, the then social care regulator, the CSCI, was keen to ask for the data to be gathered from the NMDS-SC, and encouraged its completion to support the inspection process (Skills for Care, 2008b). Inspectors had made a policy agreement to link to the NMDS-SC data wherever possible to the inspection process. The CSCI envisaged completion based on the 'collect once

and use many times' principle (Skills for Care, 2008b) and it was finally achieved as late as 2009 following technical inter-inoperability difficulties (Skills for Care, 2009c). Initially, I tried to develop a link between the need for those wanting to register individual workers (similar to professional registration), the social care workforce and the collection of data through the NMDS-SC. Positive links between the General Social Care Council (GSCC) and the NMDS-SC were developed in Phase 1. As a result, at least eight of the agreed data items for the potential registration of the social care workforce were included in the NMDS-SC. Although professional registration with the GSCC is a personal employee responsibility for professional social workers, where every social worker has to complete the registration forms and sign (and pay) for this, there is great potential here for facilitating the process. The GSCC saw the link, but never developed it. Moreover, currently the GSCC is to be abolished under a widespread review of 'arms length' organisations by the Coalition government (DH, 2011A). The registration processes for qualified social workers will be kept and transferred to the Health Professions Council (HPC). The Care Council for Wales (CCW), the Welsh counterpart of the GSCC, requested funding from the Welsh Assembly Government to develop a NMDS-SC but the economic downturn of 2009 put this on hold (Care Council Wales, 2009). In light of the above it is unlikely that overlapping registration and data collection options in the near future have much chance of developing in Wales, either.

The importance and originality of this study are that it charts the development of a process designed to improve data collection. At the outset the idea of the

NMDS-SC was to collect data about the whole social care workforce in England. As the literature review in Chapter 3 of this study reveals, very little work of this type (designing and collecting large workforce data sets) was available for reference.

The Provider Sector

In 2007-8, the net total public cost of adult social care in England was £13.34 billion (Pool, 2009). Social care in England, commissioned through the state, remains largely provided and delivered by small and medium-sized independent private employers, as has been the case since the early 1990s (Knapp et al., 2001: p.292) but there is a strong corporate presence. In the first decade following the NHS and Community Care Act 1990, residential care provided by LAs declined considerably, falling by more than half from 1997 to 2002, while LA-provided home care services dropped by 30% in the same period (Knapp et al., 2001).

Care home providers have consistently argued (Netten et al., 2002; Office of Fair Trading, 2005; Low Pay Commission, 2009) that one of the effects of the NHS Community Care Act 1990 was that LAs were still able to exercise tight limits on the fees that they paid to providers, thus reducing providers' profit margins and the amount they can reinvest in the business. However, other factors, such as over-supply in certain parts of the country, changes in the level of disability among residents, and increased regulation designed to improve both staffing levels and the quality of the built environment (Netten et al., 2002; Darton et al., 2003), have also played a part in changing the shape of the market. Many small

providers remain, but for over a decade the market has attracted more corporate and large-scale providers (Knapp et al., 2001). In turn, some larger care home providers have been particularly affected by falls in profits and other financial manoeuvres during the recession (Fahy, 2009; Mathiason, 2009; Beresford, 2011; White, 2011). The number of employers in social care underlines the complex logistical barriers to acquiring knowledge of the workforce. Interestingly, the provision of children's services appears to be developing differently. Lethbridge observed some of these differences:

> *Childcare provision is closely linked to employment policies, which are trying to expand the participation of women and single parents into the labour force. Government support for childcare is through direct service provision in some countries, but through private and voluntary provision in others. The move towards integrating childcare services with education services in several countries is helping to improve the status of childcare workers.*
>
> (Lethbridge, 2005a: p.3)

However, the availability of workforce information on children's services remains limited and the NMDS-SC has the potential to be used as a comparative source of data by the Children's Workforce Development Council (CWDC) in England. *The State of the Children's Social Care Workforce* (CWDC, 2008) uses much of the data on the children's workforce from the NMDS-SC and observes that:

> *In the private and voluntary sectors, a longstanding lack of workforce data is now being addressed by the development of the National Minimum Data Set for Social Care (NMDS-SC), which has been launched by Skills for Care*

and CWDC to capture data from the whole of social care. To date there have been fewer responses from the children's sector, although there are useful data for residential care. The NMDS-SC will be an invaluable tool to aid understanding of the nature and development of services in the private, voluntary and statutory sectors as it becomes embedded across the whole of social care.

(CWDC, 2008: p.7)

The slow uptake by children's service organisations perhaps suggests that the CWDC was ambivalent about recommending the NMDS-SC to collect its data. Its responsibility for several sectors extends beyond social care, and now includes schools and under-fives' provision, which are not included in the NMDS-SC. Nevertheless, the NMDS-SC still continues to collect some children's workforce data (Eborall & Griffiths, 2008). More recently the CWDC appears to have had a change of heart and declares:

CWDC therefore supports the use of NMDS-(SC). It is aimed primarily at social care employers but it may also be suitable for some aspects of the wider children's workforce. It is applicable to large statutory employers such as Local Authorities and small private and voluntary sector providers. It can provide detailed information to individual employers and aggregated (anonymous) data for regional and national use.

(CWDC, 2010: para. 2)

Consideration of Approaches and Use of Pilot Studies

In order to achieve a sustainable approach, preparatory steps and a partial pilot were undertaken in different regions of England and a controlled pilot of the

NMDS-SC was initiated in partnership with volunteer employers. Chapter 6 reports the work of these early stages.

During this time numerous methods to collect improved data were considered. These included making the data collection process an obligatory part of the CSCI inspection process; or using a market-driven approach, placing the responsibility to deliver data directly with employers, using a software tool that would take the required data from employers and gather it for national use. These options form part of Chapter 2. The section below briefly outlines the building of the NMDS-SC to set the following detailed chapters in a context and chronology.

Building the NMDS-SC

The lack of data and the absence of standardisation have been summarised above. My idea of a NMDS-SC developed from my assessment that there were 30 essential data items that, if these could be agreed and defined, would provide national data. This concept seemed simple. It would achieve something that the industry had not managed so far: to collect basic and agreed data in a usable format. This would contrast with the previous approach, where each stakeholder gathered information as it saw fit and in a manner it alone determined. If a common system could be developed and accepted, this solution would overcome the problems of the lack of data about the sector's main asset, its workforce.

A single source of good quality national data about the social care workforce in the NMDS-SC would be a significant step. It would help address the problem in planning within the social care sector in the absence of knowledge of the size or profile of the workforce. Other possible strategic approaches were considered. The GSCC had been charged with the responsibility of registering the entire social care workforce under the Care Standards Act 2000. However the GSCC had progressed so slowly in registering social workers, who made up only a small number of the sector, that registration of further staff was unlikely to occur. The GSCC registration process covered only qualified social workers and students of social work by the time its abolition was announced. Nonetheless, at the time of its abolition the GSCC's own website was still indicating its intentions to enlarge its remit:

> *The GSCC is currently working towards opening the register to home care workers and managers in England. This move follows an extensive consultation which showed widespread support for registration and a government announcement, in 2007, that the GSCC would be tasked with registering the home care workforce next.*
>
> (GSCC website, July 2010: since deleted)

Social workers are a small percentage of the sector's workforce at around 80,000 individuals, far less than 10% of the total social care workforce. The GSCC completed a first phase of registration in 2007. However, other social care staff do not need to register. Over and above this, there are thousands of individuals using direct payments to employ their own care workers, recently

estimated at over 263,000 directly employed individual workers (Eborall et al., 2010).

Workforce data within the NHS is more complicated but there is one overall employer for most staff (excluding general practitioners). Social care has over 40,000 employers (Fenton, 2011). I believed that it was better to set the social care data collection aims at a simple but more achievable level, as there was such a low base to start from. I started by trying to define the top 30 questions that we wanted to know about the social care workforce. The first two questions we did not know were simple but essential- how many employees are there in the sector, and where do they work?

A live online data system and warehouse to procure and store data were designed and fully operational by 2007. These are run by Skills for Care from head office in partnership with a commercial company (selected by open competition): which is contracted as the IT provider. To achieve this, the project had to be fully scoped and costed, and funding located and negotiated. Access to data using new internet capable processes was developed to allow for further developments. These included direct employer and organisational input to data. The system was designed to be able to react from the 'live' and regular user (such as a care home with over 100 staff) to the occasional annual 'user' (such as an individual employer or a very small enterprise). This was not designed to be another survey, but a continuous development tool for individuals, employers and strategic bodies. It was designed to provide continuous updated information, as well as give individual employees access to continual

professional development data and their own workforce profile in comparison to anonymised others.

Had I been more able to aggregate a national sense of the social care workforce from any other source, it may not have been necessary to develop the NMDS-SC. For my own purpose, initially the desire to gain a national picture, the available literature (which Chapter 3 reports), and the data proved impossible to synthesise. The most comprehensive of these (Hardy, 1998; Sainsbury Centre for Mental Health, 2003; Simon et al., 2003), used different analyses, combining qualitative and occasionally quantitative methods with differing objectives (see also Eborall, 2003: p.64).

The Germ of an Idea

This idea of a minimum data set for the sector's workforce came after I attended a series of six NHS workforce development meetings in the late 1990s. The NHS was developing its thinking on collecting data on its 900+ organisations (NHS Trusts) and their staff. Both workforce and job types are very complex in the NHS, and this meeting was early in the development of the NHS Electronic Staff Record system that went live in 2008.

Trying to gain interest in gathering quality workforce information in social care as opposed to the NHS was difficult at the time. As an insider I found one definite ally in a civil servant, the then lead on care and modernisation in the DH, who also had a passion for improving knowledge about the workforce in the sector. When we first met (Appendix 4), he asked me how the sector could

ever find the detailed data that would show the flow of people into and out of the sector. He drew diagrams that resembled the River Thames flowing though London as that workforce. He asked me questions, such as how old is this workforce, and how many will retire and when, and how many are currently not working but could return to work. These were all things he said were frustrating not to know in his position. This individual continued to support the NMDS-SC through to fruition until his retirement in 2007.

Needing Better Information – the Supermarket Model

In 2003 I used a supermarket analogy in a workshop with a cross-section of social care employers. I held up a handful of the popular supermarket store points cards. I asked if anyone knew what they were and did anyone have any. As I expected most had a selection of these cards. I then generated a discussion about their use. They were, to the customer, sources of bonus points and credits for their provisions or their fuel purchases. Of course, to the retailers they were a rich source of consumer information. They helped understand patterns of demand. Combining consumer purchasing information with increasingly sophisticated computerised stock control, the supermarkets rarely run out of a product before they replenish it. Added to the particular tastes of consumers in a particular area, supermarkets also know well in advance what to stock the shelves with according to the calendar, Easter eggs in advance of Easter, and aisles of cheap beer for the sporting events on TV.

I used this as an analogy for the social care sector and how well the sector knew its workforce. How could social care ever manage to plan for the future, if it did

not gain an accurate and clear understanding of its resource, its workforce and some knowledge of future events?

The Purpose of a NMDS-SC

The development of a national data set for the social care workforce was a key step toward rationalising data collection and functional analysis of what was an *ad hoc* and partial statistical process. The NMDS-SC had to be agreed and, more importantly, had to be owned by stakeholders in the sector, as will be discussed in Chapters 5, and 6. There was little point in any individual making an arbitrary decision on what any data set would comprise. Any development of this kind would have to take into consideration the whole sector and its stakeholders. I decided to be the champion for the collection of analysable, regularly collected data that would be useful to the sector. While working for Topss England, then at Skills for Care, I was able to establish this cause. One early task was to encourage key stakeholders to make some commitment to collecting better data and to radically alter methods and approaches to collection and analysis.

Savings Made by Collecting National Information

As part of an argument to collect national data the following statistics were developed. They were based on actual costs estimated by organisations on the cost of undertaking certain tasks and multiplying that across the sector. It was not very scientific but it did give the sector something to focus on as potential savings.

Skills for Care identified a number of potential savings to the sector should better workforce intelligence become available, to the order of £92m over six years. These became part of the business case for developing the NMDS-SC (Skills for Care, 2006). These could accrue to a variety of organisations across the sector. The key challenges were to

- Save employers money trying to collect their own data and provide it for them.
- Stop organisations doing their own surveys when the national source can provide this.
- Save on recruitment costs through improved planning via the use of national and local information.

It was envisaged that the NMDS-SC could save £12-15m per annum for the sector by avoiding employers and Government having to do the tasks identified above.

Chapter Summary

As this thesis will outline, despite the complexity of the sector, key organisations with a responsibility for overarching policy implementation have played crucial roles in changing this fragmented picture of the workforce to a comprehensive and sustainable form that facilitates analysis and enables modelling and forecasting. The story of how this has unfolded is detailed in this thesis. I was able to work and manage this development, utilising the research

undertaken as part of this thesis in my own job as the Head of Skills, Research and Intelligence in Skills for Care.

Establishing the NMDS-SC took over four years from concept to fruition. This thesis is partly a subjective history of these endeavours. The NMDS-SC is reported to have made a unique and significant difference in knowledge of the social care sector being referenced in *Options for Excellence* (DH, 2006a) and *Putting People First* (DH, 2007b) and more recently the first adult social care workforce strategy (DH, 2010b). The NMDS-SC has started to locate previously missing independent provider workforce data. By 2010 data were being systematically gathered, with the most detailed single data collection of this sector achieving 80% coverage in some regions, some 29,000 employers in the system and all but two of the 152 local authorities were engaged in the NMDS-SC online system by April 2010 (Eborall et al., 2010).

Overall, at the time of writing (2010), outcomes from the NMDS-SC have begun to detail the fuller picture and reveal some of the missing 'jigsaw pieces' for the social care workforce in England; as gathered in King's College London's *Social Care Workforce Periodical*, for instance (see Hussein, 2009b). The Expert Seminar paper produced by the Social Care Workforce Research Unit (2003) estimated that a high percentage (85%) of the social care workforce information was at the time unknown.

In the following chapters I will define and discuss social care; outline my research on other work on social care workforce data bases and data sets; and

discuss how the National Minimum Data Set for Social Care was devised and developed. I describe in Chapter 2 the task of developing consistency in the way the main stakeholders gather data in social care.

Chapter 3 will explain why there were so many limitations in existing published information and demonstrates the range of literature including some grey and internationally sourced literature and some cognate organisations such as health researchers in the USA and Western Australia.

In Chapter 5, I will describe three studies based around testing why the NMDS-SC was required and how it would work, and how the sector could be engaged.

I initially considered the possibility of using data collected through the regulator, whose inspection process might have been a way of obtaining information from employers on the sector's workforce. This idea is discussed as a sub-study in Chapter 6.

I will discuss the development of an interim solution in Chapter 7, including how it went live nationally and giving an update up to mid-2009. In conclusion, I will discuss the limits of this thesis and conclude with discussions of future developments and lessons learnt.

CHAPTER 2: THE SOCIAL CARE SECTOR

Introduction

In this chapter I will discuss definitions of social care and why it and the people who are its workforce are significant to public policy. Social care is now recognised as having a significant workforce (as mentioned in Chapter 1), the great majority of whom are women (many working part time) (Fenton, 2011). Employers increasingly use the migrant workforce to meet their needs (Hussein, 2011e). I will outline changes in adult social care policy that have impacted on the social care workforce, focusing on describing how government and commerce have developed a broad interest in the social care workforce. These areas form the background to the development of the NMDS-SC.

History and Background of Social Care Workforce

Historically, and long before the rise of the state, families have been the main provider and co-ordinator of social care. Historians (Laslett & Wall, 1972; Thane, 2000) have described families, and to a lesser extent charitable and philanthropic organisations, as the main supporters of older people or people with disabilities. However, historians have questioned the accuracy of perceptions about communities that existed in the past (in which everyone was seemingly embedded in a kinship structure with strong family ties) (Thane, 2000; Bond & Corner, 2004).

Even after the significant reforms of the welfare state in England in the 1940s, the informal and volunteering sector had active and important roles (Means &

Smith, 1998). Thus the changes of the 1990s need to be seen over the long-term in social care. Knapp et al. observed that:

> *The UK's social care system thus continues to evolve. As with any evolutionary process, some life forms fail to adapt and others efficiently develop the means to survive and indeed thrive in the changing environment. The challenge for central and local government has been to develop market environments for practices and providers to thrive that encourage independence, extend user choice and promote quality care.*
>
> (Knapp et al., 2001: p.284)

Their analysis highlighted that commissioning by individual LAs has not always allowed this evolution to be uniform. Terms such as 'quality' and 'best value' are always open to interpretation and variations.

The Training Organisation for Personal Social Services in England (TOPSS) (to become Topss in 2002) produced the first ever Education and Training Strategy for Social Care in 2000, *Modernising the Social Care Workforce*. It identified social care as a 'sector' noted the arrival of the General Social Care Council with its stated intention to register this whole workforce of social work and social care workers. Thane (2009) developed a concise and broad history of social care for the House of Commons Health Committee. She concluded:

> *The current system of division of social from health care, commissioned and funded by local authorities, subject to means-testing and charging came into being in 1948, with roots in the pre-war system. Over the period since 1948, especially in the 1980s and 1990s, responsibility for the care of older and disabled people shifted from institutions to the community and*

from the public to the independent sector, while charges rose. Despite well-meaning statements and efforts by successive governments, criticisms of under-funding of social care and poor integration of health and social care have continued.

(Thane, 2009: p.14)

Detailing the Workforce

Labour Force Surveys (LFS) between 1992 and 2002 demonstrated an increase in the number of employees within the social care workforce, with the number of employers also rising significantly. The shortage of staff to fill posts and the pattern of staff moving around the sector to better and more rewarding jobs are well known in social care (Eborall, 2003). This is not a new phenomenon. The Voluntary Action History Society (Grier, 2005) pointed out that childcare organisations, including Barnardo's, experienced difficulty in recruiting staff and in matching LA rates of pay as far back as 1953. The Curtis Committee report (Curtis, 1946) recognised that training and stability were needed for the social care workforce (in this instance, staff working with children in care) if they were to rise above the 'Dickensian' levels it observed and criticised. As a result, the Central Training Council in Child Care was set up in 1947.

The Seebohm Report (Seebohm, 1968) established a new structure for social care delivery, though the concept of civic right or social service was never really defined, nor was the help social workers or others would give outlined precisely. The Seebohm Committee's vision, with unified social services departments as the final link in a comprehensive, generously funded welfare state, faded within 10 years of their creation in 1971 (Pinker, 1982).

The Local Authority Social Services Act (1971) integrated separate LA departments, including children's departments, into social services departments (SSDs) which were intended to serve the needs of the family as a whole, being responsible for the old, handicapped and mentally ill, as well for children. It is in the context of these historical developments that the current workforce operates.

Defining Social Care

To understand a workforce one has to know and define the work they undertake. So what is social care today? There is no simple answer but the Department of Health has defined social care as:

> *the wide range of services designed to support people to maintain their independence, enable them to play a fuller part in society, protect them in vulnerable situations and manage complex relationships.*
>
> (DH, 2006b: p.18)

Social care is a sector that is continually changing:

> *This (our) interim report proposes nothing less than a revolution in public service delivery. We envisage the creation of a series of new social markets across all main public service areas, achieved by devolving power and responsibility from the state to the citizen.*
>
> (ACEVO, 2009: p.5)

The Institute of Public Policy Research (IPPR), in its vision for social care, *From Welfare to Wellbeing in 2020* (Kendall & Harker, 2002a), highlighted the contribution made by both the developing nature of the industry and the wide

range of services, including childcare, that it encompasses, to the lack of a clear identity for social care:

> *Social care lacks the clear identity of other public services, partly for historical reasons. Social care is a relatively recent term: some of what is now called social care used to be considered healthcare. Social care is not embodied in a single type of service, institution or organisation. It includes local authority child protection services, residential care for the elderly provided in private homes, services for people with learning disabilities delivered by the voluntary sector, plus services from a range of new agencies like Sure Start, Connexions and the Children's Fund. This contrasts with healthcare where services are provided by an easily-identifiable organisation – the NHS... Social care in general and social work in particular, also suffer from a lack of professional identity. Social work's emergence as a profession has been more tortured and contested than that of other professions, notably the medical establishment.*
>
> (Kendall & Harker, 2002a: p.1)

These elements – the state of change and lack of clear identity - are reflected in the definitions and descriptions below.

When looking to collect social care workforce data, the uncertain definition both of social care itself and of particular terms within the sector serve to complicate the task. Social care does not have clear boundaries. As described above, it overlaps with health, education, children's services, and housing, as well as other sectors. The definition of social care is also likely to change over time and according to interest. Social care itself has developed to be part of common language and a recognised sector in itself. Social care was not a term

commonly used before 2000 and the Skills for Care 'Training Strategy'; before this point, it was more commonly referred to as social services, a legacy from the development of the welfare state and Seebohm (1968). It was not until the last decade that social care became a familiar term, something reiterated in as late as 2007 by Baroness Pitkeathley in the House of Lords:

> *I reflected this morning that the words "social care" have passed into our professional and political language fairly recently. Many of us grew up using words like "care in the community", "care outside of hospital", "care when you go home" and very possibly "family care" to cover all the areas we shall be addressing today.*
>
> (Hansard, 5th May 2007: column 1587)

A distinctly smaller component of social care, although one that has dominated social services debates, comprises the qualified social workers whose status is protected by title and registered in England by the General Social Care Council (GSCC) under the Care Standards Act 2000. This group is perhaps easier to define:

> *The term 'social workers' refers to those workers trained to assess and respond to people with complex personal and social needs. It is a protected title and can only be used to refer to those workers who are qualified and registered and hold a social work qualification recognised by the General Social Care Council (GSCC).*
>
> (DH, 2006a: p.9)

Previously the broader sector was largely unrecognised and the profession of social work was the dominant and most scrutinized workforce. It is not easy to

determine when social care became a dominant term. The Central Council for Education and Training in Social Work, 1971-2001 (CCETSW) established and gave some regulatory structure to social work. The arrival of the GSCC in 2001 continued this. A search of the documents and publications of the CCETSW up to its incorporation as the GSCC in 2000, did not locate the term social care.

As Thane describes, the history of what we now term social care changed with the welfare state's arrival and more recently with the privatisation of welfare. The growth of community care in the 1980s saw an expansion of home helps or domiciliary care services, supporting people in their own homes. After the 1990s many of these services were developed by the private sector investing in social care; in addition to being typically low paid they also had little or no unionisation (Thane, 2009; Hussein 2011c).

Social care workers were hitherto unregulated and remain largely non-unionised. An earlier definition of the term did not even confine the activity to paid work or volunteering but suggested that it encompassed unbounded spheres of activity:

> *It is distinctive to social care assistance that is provided in order to help children or adult people with the activities of their daily lives and it can be provided either as paid or as unpaid work, by professionals or non-professionals and it can take place as well in the public as in the private sphere. In particular, it is distinctive to social care that it transcends the conceptual dichotomies between the public and the private, the professional and the non-professional, the paid and the unpaid.*
>
> (Kröger, 2001: p.16)

Another more lay or publicly oriented definition of social care was provided by the British Broadcasting Company (BBC):

> *There is no simple definition of social care. However, it is agreed it covers a wide range of services provided by local authorities and the independent sector to elderly people either in their own homes or in a care home. It also covers day centres which help people with daily living. Services like help with washing, dressing, feeding or assistance in going to the toilet are also included, as are meals-on-wheels and home-help for people with disabilities. It does not cover nursing care.*
>
> (BBC Online, 2008: para. 3-6)

This definition changes focus under the coalition government's first social care directive, which made no explicit reference to the workforce.

> *Social Care is an essential human need, something most of us will need at some point in our lives, whether for ourselves or those close to us. How well we look after each other says a great deal about the strength and character of our society.*

The directive goes on to say that social care should display three characteristics:

> *Freedom, Fairness and Responsibility.*
>
> (DH, 2010b: p.4)

This stood in contrast to the statements made earlier in 2006 in *Options for Excellence: Building the Social Care Workforce of the Future, which* gave the following definition:

> *'social care workers'... means primarily those working in the sector who may have vocational rather than professional qualifications (for example, domiciliary workers, personal assistants and support workers) who provide personal care and support services to individuals, families and communities to improve their lives.*
>
> (DH, 2006a: p.9)

As the following sections outline, social care is a complex field, incorporating many job titles. The development of the NMDS-SC also had to consider the thousands of providers, spread across the full spectrum of the sector (Skills for Care, 2006). As described below, providers operate from state provision through to small private businesses and that means that the social care sector is likely to change frequently as a result of social policy and labour market shifts.

Means and Smith (1998) and Means, Morbey and Smith (2002) have presented comprehensive accounts of the development of adult social care in England. They concluded that a demarcation within social care in England occurred with the appointment of the first Minister for Children, Margaret Hodge, in 2003. This established a clear differentiation of a children's sector, separate and alongside an adult social care sector, for the first time. My focus is on adult social care: largely falling, in public policy terms, within the remit of the DH in England.

Changes in Social Care Provision

I have decided to focus on the last 10-15 years, as this is the period during which the term social care became more widely understood, as distinct from

other parts of welfare recognised under the Poor Law Amendment Act 1834 or pre-welfare state. My interest is the social care workforce, but the complex and varied task of social care is necessarily intertwined with what its staff are employed to do.

> *It is surprising that… there has been little research into the people whose working lives have been most affected by… developments [in social care], even though this workforce provides an exceptional window through which to look at the social services as a whole and to assess the impact of recent change.*
>
> (Balloch et al., 1999: p.1)

As Balloch et al. (1999) observe, limited historical information on the social care workforce has made it difficult to show if and how the social care workforce has expanded or changed over time.

Highlighting the lack of evidence on the social care workforce (Eborall, 2003) is not to say that no previous research existed. However, most of this was confined to research on the social work workforce. Shortly after the first social services departments were created under the Seebohm Reforms, Carver and Edwards (1972) published a report into social workers' work time and work patterns. Some years later, another study (Knapp et al., 1981) commented on the high levels of turnover among social work staff. There were isolated reports into the much larger direct care workforce (for example, Knapp & Harissis, 1981) but, in the main, most data on the workforce was confined to monitoring

reports, such as those collected by the former Local Government Management Board concerning the number of employees in council social services departments, or the annual data packs produced by Central Council for Education and Training in Social Work (which was responsible for social work education in the UK from 1971-2000) on the numbers of students entering social work education and acquiring a social work qualification each year (Balloch et al., 1999). A major barrier to the collection of wider workforce data was the quality of information collected by local councils, who at that time made up the vast majority of social care employers. For instance, Gorbach and Sinclair (1989) concluded their study of a computerised information system for people using a home help service by saying:

> *the indicators we have discussed could not provide a complete management information system for the home help service. They provided no data on staffing levels, overtime, travelling time or contact time with the clients, on the training, supervision, or tasks of home helps or on referrals, reviews or terminations.*
>
> (Gorbach & Sinclair, 1989: p.327)

When a decision was eventually made by the DH to fund a major study into the social care workforce, the NISW Workforce Study (Balloch et al., 1999), a considerable amount of effort was needed to devise a way of designing a sampling frame from which to recruit study participants (Dundon-Smith, 1996).

While the sample eventually collected for the NISW study was broadly representative of the five local authorities in which it took place (Balloch et al., 1999), by the time the study was completed there were major reasons why data

based on local authority employees could no longer be seen as typifying the social care workforce.

There is a growing body of more recent academic research on social care, yet social work takes much of the historical information on its workforce from the NISW and CCETSW statistics and more recently the GSCC (2010). These contain some information about the types of employers involved in the sector, but less information is available about employees.

At the start of the 1970s, social service departments of LAs in England employed the vast majority of people who worked in what is now termed social care. The remainder were employed by established voluntary sector employers and the private sector (which was then only small), with some individuals also employing people for home nursing, as home helps and as companions (Eborall, 2005). During this period, the term social care was not regularly in use and the sector was more likely to be called social services, as illustrated in the opening paragraph of the Labour government's white paper, *Modernising Social Services*:

> *Social services are for all of us. At any one time up to one and a half million people in England rely on their help. And all of us are likely at some point in our lives to need to turn to social services for support, whether on our own behalf or for a family member. Often this will be at a time of personal and family crisis - the onset of mental illness, the birth of a disabled child, a family break-up, a death which leaves someone without the carer they had come to rely on.*
>
> (DH, 1998: p.27)

Prior to this, in the period after May 1979, the Conservative government began the process of changing the shape of formal social care provision from state to a mixture of public and increasingly private provision. The scale of this was immense:

> *There have been very large changes in the economy of care over the past 20 years, but much of this came before the Act. The independent sector had seen a meteoric growth in residential provision in the 1980s.*
>
> (Parker, 2002: p.2)

Kendall et al. (2003) argued that:

> *The introduction of social care markets was one of the main planks of the Conservative government's community care reforms of 1990. The Labour government, whilst emphasising collaboration rather than competition, did not reverse this policy and they clearly recognized the cost of residential care in the future and the need to look for alternatives and modernise. This opening up of social care to new providers of care was heralded as promoting user choice, a fundamental aim of the 1990 Act.*
>
> (Kendall et al., 2003: p.288)

At the macro level, the options broadened for consumers of social care, with more providers offering more variety, although consumers may not have noticed the change (Challis et al., 2006). At the individual level, people may receive high levels of support but their experiences are more variable (Manthorpe et al., 2010).

The final implementation of the NHS and Community Care Act occurred in 1993. With several years of planning and change both before and after the Act, it was not until some financial streams moved from social security to LAs that the new policy really began affect provision dramatically. Social care was changing, as laid out in the six key policy objectives which had been set out in the white paper *Caring for People* (DH, 1989a: p.2). These were to:

- enable people to live in their own homes, wherever possible, through the development of domiciliary, day and respite services;
- make practical support of carers a high priority;
- make assessment of need and good care management the cornerstones of high quality care;
- promote development of a flourishing independent sector alongside good quality public services;
- clarify the respective responsibilities of agencies, thus making it easier for them to be held to account;
- and introduce a new funding structure for social care in order to 'secure better value for taxpayers' money.

Parker (2002) considered that the intention of these community care reforms on targeting services on the most in need had been realised, but that budget constraints had led to strict assessment processes, leading to rationed services generally targeted only at people with high levels of assessed need.

The development of community care policies in the early 1990s allowed LAs radically to change their main services from residential care to alternatives aimed at keeping people in their own homes (Knapp et al., 2001). These developments combined with the demise of the traditional policies of institutional care more generally (Means and Smith, 2002: p.42).

Social care changed significantly as a result of legislation; namely the National Health Service and Community Care Act 1990. When LAs began to move their own residential services for older people to the growing independent sector, the private sector was generally composed of small entrepreneurial investors, who began to provide this care as a business. Small business owner/managers became the 'key individuals and central actors in social care delivery systems' (Kendall, 2000: p.490). These private investors contracted with LAs to provide services that the authorities were under a statutory duty to provide under the National Assistance Act 1948. This was seen as a more efficient use of public money and a way to realise the assets tied up in the many institutions that LAs sold, in many cases, to private businesses (Means and Smith, 2002). Has this had an effect on the quality of social care?

There are many judgements involved in working out whether the quality of care is good enough. 'First and foremost, the nature of social care is such that the quality of care depends intimately on the personal relationships involved; in the jargon of the economics literature, for example, it is a 'relational good'' (Ben-Ner & Gui, 2003; Kendall et al., 2003). How providers are motivated affects how they engage in such relationships with both purchasers and users, and

ultimately this has implications for the quality of care delivered. Moreover, because of user vulnerability and the unfeasibility of continuously monitoring activities, trust is always an essential ingredient in social care (Kendall et al., 2003). This complicates what might be seen as a simple process of outsourcing from LAs to the private sector (Manthorpe & Spencer, 2008).

Continuing Changes to Social Care

Through this change in social policy under the Conservative government, the public sector provision of social care was reduced in order to establish greater private ownership and competition:

> *the introduction of social care markets was one of the main planks of the Conservative government's community care reforms of 1990.*
>
> (Knapp et al., 2001: p.281)

The expansion of the independent sector and of home care in the 1970s and 1980s happened largely because many small, family-run firms catered for privately funded residents or customers. These small businesses could predict their income streams and make a reasonable profit from the business. Other providers in the voluntary sector were linked to religious, cultural and ethnic, or professional groups. In this way:

> *the 1990 Act sought to control public expenditure on placements by passing funding responsibility to local authorities. One of the effects has been to undermine providers' fairly secure fiscal environments. Many small providers remain, but recently the market has attracted more corporate and large-scale providers.*

(Knapp et al., 2001: p.292)

Under these arrangements, a range of ownership structures developed; from individuals and small companies to national organisations with boards and shareholders, and some international investment companies (Kendall et al., 2003).

One key feature of social care is the large number of employers in the sector which affects the ability of government to insist upon data returns. One of the first to seek detailed information on the private sector organisations was Lethbridge (2005a) who described the growing market share of five national and multinational companies in social care. Laing and Buisson (2004a) showed that five companies (BUPA, Four Seasons, Southern Cross, Craegmoor and Westminster) employed almost 38,000 social care staff and provided care home places for nearly 46,500 people in England with combined annual turnovers of over £927m. This consolidation (large companies buying smaller providers) has continued (Eborall et al., 2010) as major companies' shares of care homes with nursing have grown steadily. Eborall et al. (2010) estimated that 58% of care homes and 66% of places were operated by major companies, a rise from 36% and 46% a decade earlier (see comments on Southern Cross in chapters 2 and 9).

Lethbridge observed that:

> *Social care is now dominated in UK by five main companies. Private equity, venture capitalists and business groups involved in the service sector, are the main shareholders. These groups are interested in a good rate of return on their investments and change their shareholdings in these companies regularly. Apart from BUPA, these companies were set up in the 1980s and 1990s, following changes in community care legislation. They have had several changes of ownership.*
>
> (Lethbridge, 2005a: p.7)

As Laing & Buisson (2009) reported, some five years later, care homes have over the past last 20 years become increasingly the terrain of the private social care employer.

It is estimated that from the early 1970s through to the late 1990s, the number of private, 'for profit', employers in this sector grew to over 30,000 employers (Eborall, 2005). The motivations of these employers have been categorised by Kendall (2001) into three typologies: empathisers, professionals and income prioritisers. All have an increasing interest in the workforce, no matter what their motivation (Ham, 2007).

Throughout the 1990s, social care continued to be provided through market-like arrangements (Ham, 2007). The providers of social care were commissioned by LAs. Knowledge of this mix became the LAs' responsibility, as they tried to shape the provider market through their commissioning powers.

Table 1 illustrates the increased percentages of ownership of care homes provision by independent (private) sector, the public (local authorities) and the voluntary sector.

Table 1: Market share by sector and number of providers
(source: Eborall & Griffiths, 2008)

Provider	Private	*% share*	Voluntary *	*% share*	Independent total	*% share*	Councils	*% share*	NHS	*% share*	Total	% of total
Care home only	9,870	*68%*	3,251	*22%*	13,121	*91%*	1,158	*8%*	177	*1%*	14,456	78%
Care home with nursing	3,603	*89%*	404	*10%*	4,007	*99%*	29	*1%*	6	*<1%*	4,042	22%
Care home with nursing - non-medical	13	*87%*	1	*7%*	14	*93%*	0	*0%*	1	*7%*	15	<1%
Total	13,486	*73%*	3,656	*20%*	17,142	*93%*	1,187	*6%*	184	*1%*	18,513	100%

Changing Demand and Need

One important explanation for the scale of change in the 1990s is generally agreed to be the shift in demand or need for social care. Foremost amongst this are the demographic changes of an ageing society.

The population of older people in the UK is increasing, for reasons that include improved health and environmental factors (Dunnell, 2008). In the White Paper *Modernising Social Services* (DH, 1998), the then Labour government declared that its primary aims were to give greater priority to prevention and rehabilitation, and to strengthen the statutory regulation of services. It intended to do this through better quality care. Again, Knapp pointed out that this was expected to be delivered through the medium of inspection services, such as the creation of the National Care Standards Commission (NCSC), but that this body would have a further role in identifying trends and the capacity of the market:

> *According to the secretary of state it will not only be 'a tough, independent watchdog to ensure services are up to scratch' (Laing & Buisson 2000), but will – as recommended by the Royal Commission – advise the government on general trends in social care and monitor the quality and availability of provision.*
>
> (Knapp et al., 2001: p.286)

The White Paper *Caring for People* (DH, 1989a) encouraged LAs 'to make maximum use of the independent sector' and to give up their role as service provider to become that of 'enabling agency'. Minister Alan Milburn, speaking at the ADSS conference in 1999, stated: 'it is no longer who provides the social

care that matters. It is the quality of care that counts' (Knapp et al., 2001: p.287).

The shift from a system of purely local provision to a national system of quality monitoring with national standards started in 2000. This development aimed to partly reduce variation in service provision standards across the country and to seek compliance with government minimum standards. Inspection staff from LAs across the country had already been brought under one organisation, the NCSC.

Personalisation of Services

The Conservative government had encouraged independent sector provision, but New Labour stated it had no preference.

David Behan, the first Director of Social Care in the Department of Health, said at the Association of Directors of Adult Social Services conference on 17 October 2007 that the Labour government envisaged a radical shift away from the state seeing people as passive recipients and clients. He declared this was a move towards seeing people as active citizens in control, making choices away from services which are donated, to services which are co-created services and focus on assets that people have, and not just on deficits. He continued:

> *We need to create public services that are dynamic and innovative; that are constantly searching for new ways to improve and new ways to serve the public. Dynamic and innovative public services mean dynamic and innovative approaches to commissioning and contracting.*
>
> (Behan, 2008: p.4)

Long before this, the Association of Directors of Social Services (ADSS) had noted in 2002:

> *Social care provision is experiencing an unprecedented level of change, not only in models of service delivery and organisational structure – which are always developing – but also in aspects of regulation and governance.... In many parts of the country most or all of social care provision is delivered by private and voluntary organisations... a partnership approach to service delivery as a concept has been worked at with various stages of success within the restrictions of separate organisations. Recent legislation and government direction has moved this agenda one step further with the emergence of structures which encompass a number of partners within one employing organisation.*
>
> (Tarpey, 2002: p.3)

However, this view of three sets of providers was to change, as Behan (2008) had predicted. Throughout the first decade of this millennium, further changes to social care were stimulated by the encouragement and development of micro employers, or individuals using direct payments to organise their social care support (DH, 2007b; Skills for Care, 2008a). Having a budget for social care that service users can spend as they choose is part of a policy goal called personalisation (Carr & Robbins, 2009). Employees who are self-employed or working casually under these arrangements may not have the same rights as staff who are working for care organisations. Lethbridge predicted that the increasing availability of this money to purchase care work may 'stimulate the expansion of non-regulated, unskilled, untrained and undocumented labour' (Lethbridge, 2005a). She observed that in practice, this type of care worker

does not often have normal employment rights, such as cover of social rights and employment regulation. The personalisation agenda has grown and choice has become an increasing driver. Such developments as 'Slivers of Time' (Watt, 2010) and the more recent and national system being developed by the Social Care Card (socialcarecard.com) nationally and regionally (Oliver, 2009; Laia, 2011) are direct responses to giving people choice and value and new ways of using social care.

Social care is changing. Social care provision directly provided by LAs has decreased considerably since the early 1990s, and continues to do so. Many LAs have transferred or sold their in-house services, and provide very few services directly. As Eborall & Griffiths (2008) point out, the share of the market in private ownership of both the residential and domiciliary care sector has grown significantly since 1990. The coalition government is directing the focus of responsibility in society away from government and expectations away from public services to the individual (DH, 2010b). This may fragment the sector further.

The InLAWS work (ADASS & Skills for Care, 2009; DH, 2008) has enabled LAs to develop a greater understanding of what services they provide through commissioning and the makeup of the social care workforce in their localities. This is predicated on the notion that a common sense, practical approach is needed so that 'locally grown social care' takes root, using local services designed and owned by local people. The ethos of InLAWs is that localisation will reduce what are seen as wasted miles and energy that currently sees

national organisations dominate large 'best value' contracts, for example, transporting workers all over London to deliver home care. InLAWS has argued that social care should be delivered in a local area often by people who are recipients of social care in some form or have some link to or knowledge of the sector. This is seen as cost-effective. Communities would be encouraged to be responsible for their members and recipients would know who and where support comes from. This approach may be the future of social care but will not remove the need for workforce data to be collected.

The Workforce Profile

With a currently estimated size of 1.61 million people, the social care workforce in England has increased steadily over the past three decades (Eborall & Griffiths, 2008; Eborall et al., 2010). The changes in its structure and the increased numbers of employers have made the task of counting this workforce more complex. Indeed, as indicated in the previous section, there are difficulties in even identifying the parameters of the social care workforce. Nonetheless, the very concept of a social care workforce arguably started in 2000 with the publication of the first Topss Training Strategy (Topss England, 2000), as described in Chapter 1.

Compounding this complexity is the disparate and competitive nature of the sector. As Paxton and Pearce noted:

> *As small and medium enterprises, private organisations are often in direct competition with each other and usually have few or no natural connections, working in isolated societies, to the introduction and*

> *expansion of national state provided public services, there is relatively little evidence that 'bigger government' crowds out social capital and a strong civil society.*
>
> (Paxton & Pearce, 2005: p.20)

Furthermore the state can potentially play an important enabling role within the workforce without necessarily being the employer. As Wright and Gamble (1998: p.1) argued: 'In many respects the issue is not whether the state should be bigger or smaller, but how it can be smarter'. They argued that the state needs to be more directive in determining how social care is shaped to meet the challenges society will face in the future. In essence, the people that deliver social care are all that social care is. Getting a better understanding of this resource might be the start of smarter or more efficient thinking in social care.

Strategic Directors: National Training Organisations and Sector Skills Councils

As mentioned in Chapter 1, the development of Topss England enabled some provider organisations to develop formal links, in order to gain resources channelled through Topss as a conduit of government money. Training Support Implementation (TSI) programme grants are an example of this and are discussed further in Chapter 5. Organisations that were proactive and made links with Skills for Care were able to access money for training. Those who were not so involved or not members of networks and partnerships failed to gain this funding. Many smaller organisations still remain outside this link (Skills for Care, 2009e).

Evidence indicates that staff development and human resource management commitments vary considerably between employers (Gospel & Foreman, 2002). Some employers do not accept staff development or training responsibilities as their role, but, as Kendall found, these employers have a dominant interest in providing a good product, which may mean they also wish to be 'satisfied team players' (Kendall et al, 2003: p.505). The notion of adding value through workforce planning and quality human resource management has been something many have not considered (Skills for Care, 2007d& 2009a).

In general, many employers in social care find it difficult to retain their staff, and therefore have high vacancy rates. They are in states of constant recruitment (Skills for Care, 2008e). Measures of recruitment and retention have never been sophisticated or comprehensive enough to offer this complex sector the information it needs to understand itself on the micro level. Foggitt (2004) explored issues in recruitment and retention in the social care sector in the UK, considering some of the reasons why staff leave, the problems employers can have in recruiting new staff, and suggesting methods employers might use to improve recruitment and retention. Where and how employers recruit and more importantly how they retain their employees have often been an afterthought. Having said that, a small National Adult Placement Scheme (NAPS) survey was insightful because it showed the importance placed by employers on keeping their staff and maintaining consistency (Bernard, 2005).

The sector appears to have been focused on service provision and little emphasis has been given to protecting its main resource, employees. This is

reflected in research. Social care has little sector-derived research to sustain its staff and avoid the haemorrhage of staff that occurs annually in the sector. Gaining an accurate notion of size and complexity may in turn raise the sector's profile because for the first time it can be quantified. As Cohen and Prusak argued, 'going through the motions of team building or "visioning" cannot produce lasting social capital' (2001: p.185) without data.

Kendall commented that one explanation for the lack of sophisticated data on training was that the workforce was undervalued; '[the imperative] to provide better quality services [is] often unrecognised or avoided in the interests of maximising profit, governed only by the achievement of the statutory bare minimum' (Kendall et al., 2003). He pointed out that only a minority of employers are committed to keeping their staff employed. Such employers stated that they have longstanding staff and commented on the futility of 'falling out' with the LA that ultimately commissions their services.

As from 2009, the NMDS-SC allows LAs to ask prospective and current contractors to show them their NMDS-SC data. This will show LAs the turnover rate of staff in that organisation, and should be a factor in decisions that are made about future contracting choices. More recently, InLAWS (ADASS & Skills for Care, 2009; DH, 2010b) had begun the task of working with LAs to develop this sophistication in planning spending in social care.

So far I have presented the case for better information of the social care workforce and given examples of what the sector misses without it. The

following sections of this chapter continue to build the description of efforts to improve knowledge on this huge workforce.

Increasing Demand for Social Care

Social care is traditionally low paid (Fenton, 2011; Hussein 2011c). Unison and the GMB are visibly active in their support for social workers and workers in LAs, along with the British Association of Social Workers (BASW); nonetheless social care's workforce is a largely non-unionised workforce, spread over numerous employers. Privatisation has focused the attention of investors on profit and far less on the terms and conditions of their workers' employment (Matosevic et al., 2007). Recent budget reductions have forced organisations to demand even more out of their workforce.

> "*We are concerned that specialist knowledge could be lost. We are seeing more jobs combine different roles … making it harder to deliver for particular groups," says Emily Holzhausen, policy director at Carers UK.*
>
> (Brindle, 2011: para.3)

The social care workforce is already fairly 'liquid' (Hussein, 2010f; Fenton, 2011), with 15-20% turnover. It is also a starting point for many who need to work and are new arrivals in this country (migrant workers). This in itself can cause many problems for employers and service users, with problems in spoken and written English and security and identity (Hussein & Manthorpe, 2011; Moriarty et al., 2011).

Of course there are many skilled jobs in social care, working with people often with very complex needs, and the social care workforce has become

increasingly well trained over the past 15 years (Skills for Care, 2008c). However, social care still has less than half its known workforce qualified in any way (Fenton, 2011). More qualifications and skills appear to give stability and commitment to the sector (Skills for Care, 2008c; Hussein, 2011e).

The problems of achieving a quality social care workforce in England do not appear to be exclusive to England. They are to some degree replicated in other countries (Cameron & Moss, 2007). The pressure to provide services varies in different countries. Some states rely on more direct provision or, as in England, are encouraging the growth of micro purchasing services, using a given budget, often to gain home care support that is often topped up by the individual's own resources (DH, 2007b). Ungerson (2003) and Naldini and Saraceno (2008) noted that the similar use of carers' allowances by families in Italy enabled those who need care to employ workers without rights of residence but who lived locally.

Ewijk et al. (2002) commented that the percentage of the total workforce which is made up of social care workers varies significantly across states. Their figures gave Nordic countries higher levels, with Denmark (10%), Sweden (9%) and the Netherlands (7%) at the top of the list. In the UK, care workers form 5% of the workforce, with lower levels in Spain and Hungary (3%). Ewijk pointed out that most social care workers in any country are women, with the proportion up to 90% in some places. More recently, when looking at migrant workers in the social care workforce, Moriarty observed the importance of migrant workers across developed countries; she commented that while many are

female, there are also a sizable number of male social care workers from migrant backgrounds (Moriarty, 2010).

Migrant women are providing increasing amounts of social care for older people and children. Lethbridge noted they were 'part of a global transfer of female labour from low to higher income countries' (2005a: p.11). The practice of drawing on a global social care workforce to meet the needs of the richer European countries is contentious (Cangiano et al., 2009). Migrant workers could not be excluded from the development and refinement of the NMDS-SC.

Until the advent of the NMDS-SC the best social care workforce data in England were primarily based on data from LA SSDs, as annual returns to the Employers' Organisation. It routinely and systematically surveyed and collated this data relating to the social care workforce employed by LAs. However, it became increasingly limited as data because the independent sector workforce grew in size (Eborall, 2005). These data, based on SSDs are limited and hard to verify because not all make returns. The annual survey is made up of different responses each year amounting to never more than a 74% aggregated response (meaning that at best three quarters respond). Many parts of the survey get much lower responses and few questions have a full response rate. Some are even left unanswered (Eborall, 2003).

Surveys of the independent sector have been attempted but they have not been able to secure significant returns (Social and Health Care Workforce Group, 2001; Eborall, 2003). They give little more than a flavour of what the workforce

actually looks like. I attempted to locate what was known and understood about this workforce from the S&HCWFG in 2003 with no success (Appendix 17). I had no response and understood from this that there was little information available. Around the same time the DH held a conference in May 2004, *The Social Care Workforce: Developing the National Agenda*. A commitment was made there by the DH to improve data using the Sector Skills Councils (DH, 2004).

However, there had begun to be a steady call to know more about this workforce (Eborall, 2003) and sub-regional and regional research into the social care workforce was undertaken although its extent and findings are unknown as a national picture. The problems with such varied data were part of the argument to develop the NMDS-SC (Skills for Care, 2006: p.50, Table 2). Sub-regional, regional and some national surveys were available, but all with less than comprehensive results and nearly always undertaken in different ways rendering the information incompatible. The NHS, the Learning and Skills Councils, RDAs and Sector Skills Development Agencies had all spent significant monies on research with little impact.

Demand for Social Care Workforce

A growing older population has ensured that the British government has had to carefully consider what it would provide for this specific aspect of social care (Wanless, 2006). This was confirmed in a report for the Department of Work and Pensions (2006) which said in relation to older people's services:

> *Health and social care is a large employer, with a workforce of 3.4 million people (11% of the national total) in 14,000 establishments… the size of the sector means that this is still a substantial call on the potential labour pool… Overall, the majority of establishments are small, with 56% employing under 11 people, and a particularly high concentration in the 11-49 range… requiring by 2014 an additional 1.6 million people (equivalent to 47% of the current workforce) to meet needs for expansion and to replace those leaving and retiring.*
>
> (McNair & Flynn, 2006: p.6)

Not surprisingly, as the growth of new businesses providing care has developed without significant planning, the development of a workforce to undertake the tasks of social care was unplanned. The 'new' commissioning processes developed by LAs ensured that contracts to provide services were linked to varying notions of need and provision levels (CSCI, 2003). Some LAs opted for high level social care provision and others did not. Residential care has developed without any guidance about required levels of supply, in contrast to earlier planning mechanisms like *Growing Older* (DH, 1981). New day care and home care provision have grown where commissioning has allowed. Large numbers of self-funders of social care have contributed to ad hoc provision, accompanied by wide variations where individuals act as micro employers using LA funds via direct payments (Hudson, 2010).

The demand that LAs produce a Joint Strategic Needs Assessment with their local Primary Care Trust forced LAs to look more closely at what they commission or provide and what is actually required (Eborall & Griffiths, 2008).

This has been a slow process and it is only recently that the InLAWS work (see Chapter 9) has enabled LAs to know their market.

Stakeholder Interest in Sector Data

In 2001 a small group of key stakeholders from the social care sector formed the Health and Social Care Workforce Group, chaired by Skills for Care. This Group commissioned the Employers' Organisation to undertake an annual survey of the social service departments of England based on the SSD0001 LA return to the DH.

None of this information was substantial enough to enable well-informed strategic decisions on the future of this workforce and the shape of service delivery to be made. The Topss England Workforce Annual Report (Eborall, 2003) highlighted this gap and contrasted it with the increasing information being gathered by the NHS on its workforce though the establishments of Workforce Development Confederations. In contrast to public familiarity with the NHS, social care remains a largely unknown, unrecognised and consequently unconsidered sector. Until recently there was little policy interest in social care, with the training and procurement of a workforce to deliver care only cogently assembled in the first adult social care workforce strategy from the Department of Health (2010b). This was recently revisited by the current coalition government through the Health and Social Care Bill that went before Parliament in January 2011, containing provisions that cover five main themes; described online as:

1. Strengthening commissioning of NHS services,
2. Increasing democratic accountability and public voice,
3. Liberating provision of NHS services,
4. Strengthening public health services, and
5. Reforming health and care arm's-length bodies.

(DH , 2011b)

Topss England had attempted to highlight the issues of raising the skills of the social care workforce in 2000 with its training strategy (Topss England, 2000) (see Chapter 1). In the absence of a coherent strategy, previous developments had largely been organic in nature through regulators and non-departmental public bodies. These included Skills for Care (formerly Topss England), the General Social Care Council, the Social Care Institute for Excellence and the Commission for Social Care Inspection.

As mentioned, awareness of the relevance of the social care sector and its workforce has only developed recently (DH, 2008). Regional Development Agencies were asked in the late 1990s to promote and develop their local industries and develop these workforces. This in turn raised the profile and significance of their workforce, locally, regionally and nationally, in both new industry and geographical terms through the Regional Development Agencies Act 1998. Significantly none of these recognised the social care workforce in their early documents (One North East, 2001). By 2006 social care was listed as one of nine important sectors of employment in the North East Region (One North East, 2008).

This pattern of failing to recognise the social care sector was replicated across England. The NHS has always had a poor understanding of social care and found it difficult to quantify the overlap and relationship of health and social care. It did not recognise the social care workforce it employed. As Eborall found, the NHS employed 62,000 staff who had all or some social care tasks in their jobs but the number was 'open to debate' because of classification complications (Eborall, 2005: p.36). Better data has since allowed the revision of this figure to 73,000 (Eborall et al., 2010). The NHS relies heavily on social care as a 'buffer zone', keeping people in their homes and out of hospitals. Understanding this relationship was a problem at national and regional levels, where the NHS developed more regionally autonomous structures, and focused upon future training and provision for service delivery. The NHS Workforce Development Confederations became a reality in April 2001. Twenty-four Confederations replaced 43 Education and Training Consortia until 2005, when funding cuts led to their demise. The relationship between locally delivered social care and centrally funded health policy has always been confusing, as discussed by Lewis (2002). This has continued when looking at the units costs of social care, because the NHS does not have information on that workforce (Curtis, 2009).

The launch in the education sector of the Learning Skills Council (LSC) in 2000 confirmed interest in the practical application of skills. The social care sector became an LSC national priority area, and a main concern for local LSCs (Gospel & Thomson, 2003). Their objective was to support the funding of training in this largely unqualified sector; even though, as Eborall (2003) points out, little was

accurately known about the size of the sector. The Regional Development Agency in the North East of England, One North East, observed that 'When health and social care are combined, they account for the employment of over 130,000 employees, financially enabling over 400,000 of our population'. It also stated that social care in the North East of England was one of the top 10 workforces with skills shortages (Watson & Lamprecht, 2002: p.3). However, social care was becoming acknowledged and recognised as a sizeable workforce and a discrete sector across England, and more organisations and observers have incorporated social care into their thinking (Mell & Bewick, 2006). Between four to eight percent of the all the RDAs' overall workforce is estimated to be working in social care (Watson & Lamprecht, 2002) and it is increasingly being acknowledged as an important workforce.

Increased Investment

Considerable money has been spent on social care activities, and spending is estimated to have grown by 53% or £4.3 billion on average per annum from just over £9 billion to just over £14 billion in the 10 years from 1997 (DH & Local Authority Adult Social Services, 2011). Much of this has been invested through numerous quasi-government bodies over the last 10 years into the social care sector for training and improving this workforce. These organisations and investment have included over the last decade: 47 Learning Skills Councils and 27 Workforce Development Confederations (NHS) (absorbed into Strategic Health Authorities in England). These, along with nine Regional Development Agencies, have an interest in the social care workforce. More recent

developments included the launch in 2005 of the Sector Skills Council for social care (Skills for Care), later split into Adult Services and the Children's Workforce Development Council (CWDC) in 2006.

All these bodies have been seeking workforce information (Eborall, 2003). Although numerous sources of data were available, few have national coverage, or are comprehensive. As noted earlier in this chapter, it is impossible to conduct any sophisticated statistical analysis of this data as there have been so many forms collected, all different, with different variables. According to Eborall (2003: p.67): 'The available information... needs careful interpretation as the methodologies, coverage and definitions vary.'

Information is further collected in the DH Delivery Improvement Statement (DIS) annual survey reports, which ask social services departments some workforce questions (along with other questions). However, the DIS is primarily about service delivery quality and only requires information from LAs, and not the independent sector.

Social Care in Other Sectors

An additional element of complexity is the workforce that delivers social care in settings outside those perceived as traditional social care. These are employees who perhaps operate in the NHS, housing, or education sectors. Skills for Care developed a 'footprint' of the workforce covered. The NMDS-SC aimed in time to cover all those employed, including those service users who employ their own personal assistants and those in ancillary work, such as drivers and cooks. The

NMDS-SC will, of course, always overlap with 'footprints' of other Sector Skill Councils that have a focus on children, health and housing. However, this is not necessarily a problem. For example: the CWDC now uses the NMDS-SC as its major source of information on its workforce.

The Missing Statistics on the Social Care Workforce

Using data from the Office for National Statistics (ONS) 1997-1999 Labour Force Survey, Cameron and Moss (2007) estimated that between 1997 and 1999, there were about 1.3 million care workers in the UK, accounting for about 5% of the total UK workforce. Eborall and Griffiths (2008) offer the most accurate update of this workforce at that date, though it is not given as a percentage of the overall workforce in England.

Eborall (2003) had observed that estimating the size of this social care workforce in England was problematic for a number of reasons at the time:

- Boundaries of the 'footprint' of social care are unclear and many elements of care overlap with other areas of work such as health and education.
- There is limited information on the independent sector.
- Little research has been done on the domiciliary workforce and 'double counting' of this workforce was a problem.
- Similar problems applied with those who work through agencies.
- Double counting of the part time workforce was a problem.

- The size of the casual paid workforce is largely unknown.
- The problem of the way the headcount (number of persons) is undertaken varies: some are whole time equivalents and others full time.
- Definitions of full or part time work are not clear.
- Confusion exists over the counting of administrative, domestic and support.
- Occupational definitions of job roles developed for NMDS vary considerably, as does geographical coverage.
- Some data is UK, others for England, Wales or Great Britain.
- Extracting data is problematic because various occupational and industrial classifications are used.
- Standard Industrial Classifications (SIC92) and Standard Occupational Classifications (SOC 1990 and SOC 2000) are not easy to use when defining care work and groups of care workers.
- The inclusion of care home and domiciliary care workers in the single code (6115) in SOC 2000 is particularly problematic.

(Eborall, 2003)

Within these caveats, Eborall later (2005) estimated the core workforce at 929,000, including those working for LAs, domiciliary care, the NHS and those in the independent sector (private and voluntary), later revised to 1.6 million in Eborall et al. (2010). This is part of a wider workforce, which includes people

working in early years services (with children), other NHS staff with caring functions and adoptions services, and is estimated to be 1.55 million. By September 2011, approximately 1.19 million people were employed by the NHS Information Centre (HSCIC, 2011).

Eborall found (2005: p.26) that although more recent data was available, counting the social care workforce was still problematic, particularly in relation to the independent sector workforce, which she estimated to account for over 70% of the social care workforce as a whole. Only by 2008 did accurate figures emerge from the use of the NMDS-SC (Eborall & Griffiths, 2008; updated in Eborall et al., 2010).

Gathering Data

Gathering information on the workforce has been a recent development. As part of the Department of Health National Training Strategy and Human Resource Development Strategy Grants in 2003, for the first time (the then) 150 LAs with social service responsibility had an incentive to provide information both on both their own staff, and those employed in the voluntary and private sector contracting services through them. These figures were reported in the Social Services Inspectorates September 2003 performance and assessment monitoring (DH, 2003d). This in itself raised issues of reliability and accuracy.

How LAs collected this information - and to what extent all their providers were included - was not clear. The question of those who were contracted and those who were non-contracted providers being included or not, and the issue of

those falling outside the LA's area, added to the difficulty. There was the possibility of multiple counting. For example, a Home Care study in 2003 found that 39% of domiciliary care agencies provided services to more than one LA (McClimont & Grove, 2004). Some LAs provided no information at all, while data from others was problematic, with the total figures looking suspiciously low. According to Eborall (2003), even with this figure adjusted to take into account missing data, there were then still about a million workers, and this did not take into account staff who were employed by providers not contracting with LAs or those employed by the NHS.

Because SSI figures were problematic and unverifiable, and Commission for Social Care Inspection data gathered as part of inspection processes were not available for analysis, in the early years of this decade I concluded that accurate figures for the nation's social care workforce were unlikely to be available.

Three further points relate to the complexity of data in this area. These are 1) the use of agency workers, 2) the growth of casual working and 3) the possibility of people holding more than one job. These areas are briefly discussed below in the conclusion to this section.

A further complex and rarely researched area of this workforce is the use of employment agencies that provide staff on a temporary or permanent basis (an exception to this is Cornes et al. [2010]). The Social Care & Health Workforce Group survey (Employers' Organisation, 2003) estimated there were 4500 long-term staff (employed for more than a month) employed by LAs in England via

agencies. Most were working with adults. Only 4% were employed in children's and occupational therapy services. Eborall suggested there could be as many as 8400 (whole time equivalent) long-term agency staff working in the local authority services at the end of September 2004 (Eborall, 2005). In 2009, a larger number of LAs entered the NMDS-SC. This has begun to identify the numbers of agency staff working in LAs in adult social care. Nonetheless, the NMDS-SC is not comprehensive in this regard at the time of writing (2010).

Eborall (2005) found evidence that the overall social care workforce was shrinking in quantity, mainly in care homes and domiciliary care. As a result the changing patterns of social care delivery were moving to a more informal or cash-based provision, so statistics were not providing a clear picture. This may increase with the focus on new ways to deliver social care (DH, 2005), such as personal budgets.

The estimated overall UK social care workforce was said by Eborall (2003) to be underestimated at 2.2 million. Eborall also considered that the figure, derived through the government's small and medium sized employers (SME) statistics, underestimates the total workforce because of the way social care is counted as it is not the LA's main activity. Field and domiciliary staff are typically excluded from this classification, as are casual workers, those paid in cash (always hard to quantify) and those who have several jobs, making the collection of quality data even more complex (Eborall, 2003).

Conclusion and some Key Questions

Having considered the history of social care and its workforce, a number of questions remain to be answered. How many people work in the social care sector and for how many employers? What are the shortages in this workforce, are employees appropriately trained for their work, and are they developing as the nature of social care changes for the future? Why do they enter the sector, why do they leave, and where do they go? What are the factors that keep pay scales low and attract mainly part-time women workers to bear the weight of many social care tasks? How do employers or others train this workforce for the future, and ensure that it delivers the highest standard of service to the people who need care? The poor quality of workforce data made most of these questions unanswerable until the NMDS-SC emerged.

Eborall & Griffiths (2008) said that the development of the NMDS-SC had enabled better data estimates of the social care workforce to be developed than had ever before been possible. Professor David Croisdale-Appleby said in the preface of the 2010 *State of the Adult Social Care Workforce* that planners across the sector at regional and national level increasingly regard NMDS-SC information as definitive (Eborall et al., 2010).

The composition of the social care workforce is complex, and the notion of improving understanding of that workforce through the development of the NMDS-SC reflected this complexity. The next chapter looks at the scope of literature about gathering large workforce data sets and previous work on

defining and collecting such information both in the UK and internationally in social care or elsewhere.

CHAPTER 3: REVIEW OF THE LITERATURE

Introduction

Having discussed the background to the social care workforce and its development in Chapter 2, this chapter outlines some of the existing published literature on developing information systems for workforce planning.

In undertaking this review I intended to identify relevant literature and any gaps. I intended to find any new contributions and to identify any seminal works so to increase the breadth of my knowledge as part of this thesis.

Technology was not the same as it is now when I started this PhD. I originally used the British Library catalogue and that of King's College London to search journals and CD-Rom databases. As time progressed, technology changed and more searching was undertaken using electronic databases online.

Initial research retrieved on the social care workforce was small in quantity. There was some research on social workers, for example (Knapp et al., 1981; Knapp, 1986) but little on others working in social care (Knapp & Harissis, 1981; Knapp, 1985). This also applied internationally.

My first attempt to undertake a review of the literature on modernising workforce data collection in social care or elsewhere began before any development of national minimum data set(s) or systems, in January 2004. Further searches took place in August 2005 and January 2006. Searches were then carried out regularly through to mid-2011. Searches of the following key words were undertaken: workforce data, data systems, social care and

workforce, data warehouse, and later included national minimum data set(s), and minimum data sets.

What became increasingly apparent was, as Chapter 2 explained, before 2004 and the publication of the first *State of the Social Care Workforce* report (Eborall, 2003), little work analysing the social care workforce had been completed. I was not looking for literature on social care itself. Very little literature emerged that was relevant to improving the collection of social care workforce information.

Background

The explanation for the lack of available literature is partly historical.

Social care workforce information falls into two distinct eras: pre-2007 and after the emergence of the NMDS-SC in 2007.

Before 2007

As explained in Chapter 2, workforce reforms had been implemented in the 1970s following the Seebohm Committee's review of LA social services in England and Wales (Seebohm, 1968). Prior to the reforms following this review (Health Service and Public Health Act 1968), responsibility for the social care workforce rested with the LA. After the reforms, care provision was slowly contracted out to the private sector, into the late 1970s. This process was accelerated following the NHS Community Care Act 1990. This meant that the information systems that existed were often locally specific: different LAs collected different information, and there was no reason for information

systems to be compatible with each other. The SSD001 return completed by LAs for the DH (which started in the 1990s and ended in 2011) obtained limited consistent information from every local LA, but this data was not used proactively for workforce planning beyond documenting a headcount of the number of people employed by councils with CSSR responsibilities. Collecting data at local level concealed the size of the workforce nationally and it was not until publication of the white paper *Modernising Social Services* (DH, 1998) that it was widely realised that over a million people were employed in social care.

In this chapter, available literature is used to provide some understanding of the concepts most central to positioning this work in perspective. The key sections in this chapter cover the workforce, historical background, the tensions between workforce planning and regulation, the search strategy employed, the results and a final comment on the recent literature.

What is the Workforce?

It is important to define the terms being used before continuing any further. Is the workforce thought of as only those who get paid for their 'work', or is everyone who contributes in some way to delivering social care in England included in the definition?

The distinction between paid or unpaid staffing in the social care sector was an issue raised by Wanless (2006) when he estimated the size of the social care workforce at over four million people, including unpaid carers. In its report *Options for Excellence*, the DH (2006a) estimated the combined paid and unpaid

social care workforce might be even greater, at five million people. This report maintained it was important to recognise the contribution made by unpaid carers to the social care sector. If it were paid for, this informal care would represent an estimated £57 billion per year (Carers UK, 2002), although this is only a 'guesstimate' calculation. Moreover, family carers may work as carers to a greater or a limited extent. The DH noted:

> *Currently, more than three million people – one in seven of the workforce in the UK – juggle the responsibilities of caring and paid employment and this is in part due to the flexibility that not just large but also small and medium employers provide for their employees.*
>
> (DH, 2008: p.98)

Informal social care also occurs within neighbourly and wider family relationships. Direct Payments are a form of publicly funded social care where money is paid directly to people who are eligible for publicly funded social care. Direct Payments allow them to make their own choices about the care they buy, and how they get their support. Within an agreed support plan these payments will have an impact in future, perhaps as more unpaid family carers begin to get or seek greater income from their efforts; in addition to or instead of benefits such as, for example, the Carers' Allowance (Skills for Care, 2008a).

Despite well-established statistics on informal care, the main cost of social care lies in paying the wages of the workforce. It is the paid workforce that is most widely recognised as comprising the social care sector. Policy changes over the last 10 years have seen the reduction of residential establishments in favour of

people being supported at home, a phenomenon which 'highlights the emerging emphasis on prevention and rehabilitation, which aims to reduce demand for high intensity services' (Wanless, 2006: p.24). This further changes the shape of social care and may increase or alter the efforts of carers (Phillips, 2007). Despite these changes, the paid workforce is still necessary.

Historical Background to Workforce Planning

Originally called manpower planning, workforce planning is a term taken from the business sector, where it was originally used to anticipate change that would require new skills, knowledge and expertise as well as potential loss through retirement (Sinclair & Robinson, 2003). Human resource planning is a variant of this term. Workforce planning helps organisations make sure they have the right people with the right skills doing the right jobs. In the early part of the 21st Century, as Chapter 1 indicated, some social care stakeholders were keen to bring a more scientific approach to social care planning and supported the development of the NMDS-SC, as ultimately did Skills for Care. It was recognised that social care needed a tool both to understand social care at present and to provide intelligence about the workforce as it develops (Cracknell, 2010; Smith, 2011).

The importance of knowing what you have now in order to plan what you need is fundamental to structured and planned development. In business a stock-take is used to make decisions about what needs to be ordered and to determine what is moving and what is not. With such poor information on the social care workforce it was very difficult to know its shape and size, or any characteristics

of its employees. This lack of a stock-take or knowing the exact position is the nub of the task for the 21st-century social care workforce planner.

The Tension between Workforce Planning and Regulation

Social care employers need to plan how to deliver their services. The service will depend on what is required, and good employers will ensure they have a quality workforce, trained to undertake social care in the most appropriate and cost effective manner. Employers need information on their workers and the work they do in order to achieve this. Good employers, one presumes, know some of these answers, but being able to access better information and using these figures to plan their work are likely to benefit them all.

Improved intelligence would allow employers to plan their services and ensure that their staff have the right skills for the job, which in turn should improve the quality of the service they deliver. It may, in turn, cost less. If employers have a low staff turnover, then they will spend less time and resources on recruiting. The logic follows that they should have more time to focus on managing the quality of services they deliver, their prime purpose, perhaps also in making savings and efficiencies; the combined effect of these changes should in many cases result in employers increasing their profit margin. Workforce intelligence is something gained from increasing understanding of the workforce. Improved and more accurate data become the information on which one acts. Using the statistics, a manager transposes these into understanding, and thereby gains greater intelligence of the subject (Zuleeg, 2003).

Regulation (the monitoring of standards) currently plays a significant part in how social care is delivered. Workforce surveillance and control are dominated by standards. The arrival of National Minimum Standards (NMS) (Care Standards Act, 2000) established the standards that social care needs to achieve. The role of the Care Quality Commission is to act as the independent regulator of all NHS and adult social care in England. Its mission is to make sure better care is provided for everyone: in hospital, in a care home, in their own homes, or elsewhere (CQC, 2011). Research undertaken by Skills for Care (2011a) suggests the worst performing homes have lower proportions of staff with relevant qualifications and the higher rated homes had the highest percentages of appropriately qualified managers. However, Skills for Care acknowledged the incompleteness of the worker data records.

Regulators ensure these standards are met in those social care settings that are regulated under the Health and Social Care Act 2008. Until the NHS and Community Care Act 1990, the inspection process was formerly the responsibility of each LA. This change to national standards is the fruit of revised inspection policy over the last 10 years, taking the inspection responsibility away from local and variable systems into a national framework. The intention was to achieve consistent standards. As mentioned earlier in this chapter, not all social care is formal or delivered through established processes. There are millions of social care transactions going on weekly outside regulation. Regulating social care is a complex issue, and the growth of personalisation in social care raises questions about its future, if this movement

also indicates a trend towards the casualisation of the social care workforce (Balloch, 2007; Brindle, 2008).

Regulating the Workforce

The task of regulating, registering and establishing a professional status upon some of those working in social care started with the establishment of the General Social Care Council (a non-departmental public body established in October 2001 under the Care Standards Act 2000). This set up a register of social workers; the title of social worker being protected under Section 61 of the Care Standards Act (2000). This group is relatively small in number, at 77,922 individuals actually working (Eborall, Fenton & Woodrow, 2010: p.7), although the statistics showed higher numbers registered, with the GSCC at 82,875 (GSCC, 2010: p.7).

There have been long-standing debates about whether the rest of the social care workforce could or should be registered. Policy in 2009 was that this might become voluntary for home care workers and managers in 2010 (DH, 2009b). However, as mentioned, the GSCC was one of the Quasi Non-Government Organisations (quangos) to be abolished by the Coalition government (announced October 2010). Registration of the social care workforce beyond social workers is not currently a government policy in England. In February 2011, the Government published the Command Paper *Enabling Excellence; Autonomy and Accountability for Healthcare Workers and Social Care Workers*, proposing the DH will, by the end of 2013, explore with the HPC establishing a voluntary register of adult social care workers in England (DH, 2011a).

The GSCC was also responsible for the first England-wide Codes of Practice (now with Skills for Care), providing guidance for those who work in social care (Section 62 of the Care Standards Act 2000). These perform the function of establishing standards of conduct and practice for both employers and employees. However, these Codes of Practice only regulate the behaviour and conduct of part of the the social care workforce: social workers. They may improve its levels of professionalism and also offer elements of public protection by enabling the profession to discipline and de-register errant members of the social work profession (McLaughlin, 2007; Blewett et al., 2008). The GSCC website has distributed over 1.5 million copies of the Codes of Practice to employers and social care workers across England. The establishment of these Codes meant that social care had, for the first time, regulation akin to that of doctors and nurses (GSCC, 2010) but the restrictions of registration mean that as a workforce planning tool, the GSCC only holds data on those in the social work profession.

The CQC apparently uses the Code of Practice for Social Care Employers when enforcing care standards in England as part of its inspection process (McLaughlin, 2007) but there is no evidence available to ascertain if this is so.

Literature related to modernising workforce data collection in social care

The literature search established that very little comprehensive or significant writing about the social care sector and workforce data collection had been undertaken. There is no overarching analysis of the sector, owing largely to

poor access to workforce data outside of the first Topss England Annual Report (Eborall, 2003). The literature found on developing data systems and technical issues relating to workforce intelligence has largely been from other industries and countries outside England. An overview of the social care workforce literature, excluding that related to social work unless subsumed under social care, is presented in the next section.

Search Strategy

A comprehensive search strategy was developed using the following data sources in 2004:

Table 2: Searches conducted

Date	Source	Search terms	Items retrieved	Relevant to social care workforce data
January 2004	• 55 databases in the British Library including: • CINAHL • EMBASE • UK theses • International bibliography of social sciences- (PhDs) • MEDILINE/ • PSYCHOINFO/ • Thesis.com • ULRICHS online • Social sciences gateway • Social care online	Workforce planning/ social care workforce/ workforce intelligence/ workforce data/ data warehouse/ minimum Data Set/ National workforce	10	2
	• CINAHL	Workforce data	13	0
		Data warehouse	15	2
		Social care workforce	15	0
		National Minimum Data Set	0	0
	ASSIA	Social care workforce	0	0

		Minimum data set or MDS	82	0
	Social care online	Minimum data set or MDS	29	3
	Social sciences Information gateway	MDS	0	0
		Workforce data/ data warehouse	6	1
		Workforce/ data warehouse etc	161 (see text – single word searches)	8
	UK theses	Workforce/ Social care	3	0
	Books and articles	all	153	5
			Total 434	17

The following sources were also used:

- library catalogues (British Library, King's College Library);
- internet search engines;
- hand searches of key journals in this area (*Community Care*, *Health and Social Care in the Community*).

These were searched using the following free text words or thesaurus terms:

- workforce
- workforce data
- data systems

- data warehouse
- national minimum data set(s)
- National Minimum Data Set – social Care NMDS-SC (Once established)
- minimum data sets
- social care and workforce
- workforce information
- workforce intelligence

Searches on all the above keywords were undertaken. All permutations of the above were made.

Initial searches took place in January 2004 and were repeated in August 2005 and January 2006. The final searches took place in March 2010 and updated in September 2011, and these are reported briefly in this chapter.

Search Processes

My findings indicated clear problems, for the purpose of this study, with the type of research identified. There was little relevant work in the area of social care workforce composition; and even where it did exist, it focused mainly on related issues such as recruitment and retention, and training and skill development (e.g. Schindler, 1987; Kent County Council, 1993; Sainsbury Centre for Mental Health, 2000 & 2003). Some material in table 3 was rated as relevant as it was tangentially of interest to my thesis, inferring or openly advocating the

need for quality information. A Confederation of British Industry (CBI) publication from 1988 made the point that employers (for example Barclays, Boots, British Telecom [now BT]) ought to know the age profiles of their workforce to spot trends and plan ahead. See Table 3: Databases on employment and workforces accessed in 2004.

Table 3: Summary of Material Retrieved in 2004

Source	Topic	Application to Workforce data collection systems
'Nursing Infomatics' (Goossen et al., 2000)	New technology in nursing practice	No relevance.
'The Benefits of Implementing a New Skin Care…' (Bale et al., 2004)	Skin care and chronic wounds database development.	No relevance.
Profile of the Workforce: Northern Ireland 2001 (Equality Commission for Northern Ireland, 2001)	Very small survey of the 2001 monitoring returns local government. No direct relevance. Did not give data detail.	No relevance.

Kent Workforce profile (Kent County Council, 1993)	A comprehensive study of the workforce employed by the County Council. Does not mention social care or social work. Compares national trends and labour market projections for 1980-2001.	Demonstrated the demand for data.
Women in the workforce (Research Planning Division of the NZ Department of Labour, 1980)	A study that recognises the growing number of women in the labour force - does not identify women in the social care workforce.	No direct relevance to social care.
Global strategies for managing a diverse	A strategic thinking paper.	No direct relevance to social care.

workforce (Carrell et al., 1995)		
Nurse Workforce Planning (Hurst, 1993)	A detailed study applying workforce planning to nursing provision. Suggests that nursing is the largest workforce in the UK and the largest item of NHS expenditure.	Highlights the constant quest for better data and information.
Everybody's Business - Winning the Workforce 2000 Challenge (Webb-Vignery & Lynch, 1992)	A US study into how organisational changes for dysfunctional or minority groups based on the traditional or majority ways do little but move the organisation temporarily. An interesting study little related to UK social care.	No direct relevance to social care.

Workforce 2000 – An Agenda for Action (CBI, 1988)	Written in 1988, a Manpower publication looking at what the workforce in 2000 will look like, suggesting it will be significantly different.	Little direct relevance to social care.
The Missing Workforce (Sargent, 1989)	An institute of Personnel book primarily investigating absenteeism. The book focuses on the estimated 5% of the workforce who fail to attend work.	Little or no direct relevance to social care.
Human Resource Vision: Managing a Quality Workforce (Connock, 1991)	A comprehensive study of the main components and reasons for HR management. It places the role of HR strategies and a HR vision as high up and alongside that of budgets and economics.	No data section. No direct relevance to social care.

Workforce & Training in Personal Social Services - A Programme for Action (Peryer & Goodenough, 1992)	Two brief pamphlets. 1 is a summary version and 2 is full text. First line: 'social services are big business. An effective network of welfare services has to be responsible to local communities. If local Authorities ceased to exist they would have to be re-invented.'	Points out there is a lack of information - suggests LA collects it.
Privatization and the welfare state - Implications for consumers and the workforce (Morgan, 1995)	Main focus is section one -privatisation of the welfare state. Other sections look at education /public services-police/post office and rail. A final chapter looks at the effects on the workforce of privatisation.	Mainly on privatisation of the workforce.

Independent Care Sector - pay, terms and conditions (Pay and Workforce Research, 1998)	Pay and conditions study	No workforce data collection relevance
'Passing the torch - managing succession in the Western Australian public sector' (Ministry of the Premier and Cabinet, 1999)	Prime concern the ageing workforce and the prospect of mass retirement. This being a problem and opportunity. Main focus is government bodies, public sector, does not identify SC specifically. Second booklet 485 - strategic people planning. Pamphlet based on the principles and understanding of basic workforce planning. Data source: Government	Workforce planning strategies. No data section.

	Western Australia anonymised public records.	
Workforce Analysis: Trends and policy issues for the future of the health workforce (Dengie, 1999)	A study of trends realised through workforce planning such as projected shortages in doctors and nurses and policy issues related to these. Uses NHS workforce data.	NHS-based . Importance of taking care of workforce but nothing on collecting data. Does indicate the need for quality data
Finding and Keeping: Review of recruitment and retention (Sainsbury Centre for Mental Health, 2000)	A study of recruitment and retention issues in the mental health workforce. Detail of who works where doing what , the stresses and strains on the workforce-why people leave and the problems in recruiting and keeping new staff.	MH focus. Premise the need to manage and support a workforce. Talks of the need for data and making use of it.

Strategic People Planning - an overview of workforce planning (Ministry of Premier and Cabinet, 2000)	This points out that data on social workers is highly fragmented and unsatisfactory. Makes good links between people who enjoy their job/ feel committed and retention of staff and why.	Says data is poor and it needs to be better
Mental Health National Service Framework. (NHS Executive, 2001)	Strategic MH paper No data information	No relevance to social care workforce data collection.
Workforce Transitions: From the profit to the non-profit sector (Stein, 2002)	This book looks at the USA trend to displace professional managers in corporations, downsizing the corporate sector a (this is described as their 'falling from grace'-followed	USA, no direct relevance. All about changing sectors for job satisfaction.

	by a period of disenchantment) and the growth of the non-profit sector -defined under tax differentials as educational, Does not address employers or sectors counting the data on their workforce.	
Scottish Social Services Workforce (Scottish Executive, 2002)	A briefing paper on the social work workforce.	No mention of workforce data
A Health Service for All Talents: Developing the NHS (DH, 2000)	Strategic paper on NHS	Argues the need for quality information not on collection.

Mental Health - Workforce Planner's Guide (Sainsbury Centre for Mental Health, 2003)	Links planning to good current information	MH – needs better data.
Social Care at the frontline: A worldwide study of paraprofessionals (Schindler & Brawley, 1987)	A very interesting study of training and use of paraprofessionals as front line workers to provide social care in thirteen developed and developing countries.	Developing SC in 13 3rd world countries and their use of unskilled workers,

Social Service Department Workforce Surveys 1996-2004 (Employers' Organisation, 1996)	SSD001 surveys- Annual survey undertaken on behalf of the social care and health workforce group by the Employers organization based on the returns of the SSD001 from LA's in September each year.	Relevant. Surveys and poor data issues. Discussed in text as a main provider of social care workforce intelligence before the NMDS-SC.
Intranet Data Warehouse (Tanler, 1997)	This book is based on developing data warehouse systems and making them operate though the intranet, thus increasing access to the information.	Data sets- useful though not directly relevant as technology moves on
Mapping the care workforce: Supporting joined-up thinking (Cameron et al., 2003)	Specific to child care and social work	Secondry analysis of LFS

The Data Warehouse Toolkit (Kimball & Ross, 2002)	An revised earlier publication (1996). A 'toolkit for using dimensional modeling to develop a data warehouse that allows industry to make better decisions based on better data collected. This book is a comprehensive step by step guide to building a data storage facility. 'A one stop shop for dimensional modeling techniques'. To my amazement the book does not reference or contain a bibliography for further reading.	Highly technical book on data toolkits and modeling data. Again proved to be somewhat old as technology moves on - good introduction to vocabulary and terms
Data Warehouse Project Management (Adelman & Terpeluk, 2000)	Details of establishing a data warehouse project.	Technical and dated

Applying numbers & IT in health and social care (Doolan, 1999)	A book about the maths and computer skills people starting in the world of health and social care might need to work and progress in a career in the sector. Not too useful to my research	About data possessing and IT skills – no use
Forensic Social Work (Central Council for Education and Training in Social Work, 1995)	A CCETSW paper-The importance of information in social work. Did not discuss social care or data sets.	
The primary care workforce (Mathie, 1996)	A service study of primary care in the NHS	Service based information

Operational Modeling for Planning and Management of Health Care Resources (Harper, 2002)	A PhD looking at services in health.	
Vision of Social Care in 2020: demise of SW & SSDs (Kendall & Harker, 2002b)	An interesting stab at the future of social care, then 18 years ahead.	This recognised the need for good quality workforce information.
Human Resource Forecasting and Strategy Development (London et al., 1990)	Forecasting not data collection	No direct relevance to social care but indicates the need for good quality workforce information
Data Warehouse	A technical book on data warehouse	No direct relevance to social care

Management (Adelman & Terpeluk, 2000)	development	
Impossible Data Warehouse Situations (Adelman, 2002)	A technical book looking at warehouse solutions	No direct relevance to social care
'The Migration of Nurses...' (Buchan & Sochalski, 2004)	Nurse mobility and migration study	
Belgian Hospitals Nursing Minimum Data Set (Vanden Boer & Delesie, 1996)	Using a minimum data set to improve bed allocation in hospitals.	The use of data in research

'Strategic State-Led Nursing Workforce Initiatives…' (Cleary et al., 2005)	An example of the use of data bases to collect information used significantly to collect information of on a nursing shortage across five states in the USA.	Not directly relevant but a good indicator of how to use data on a workforce
'Australian National Minimum data set…' (Copeland & Conroy, 2001)	A practitioners data set based around work with A&D clients and their treatment	
'Profile of the physiotherapy Profession…' (Anderson et al., 2005)	A study using a data set workforce information gathered to profile the profession in NSW	

'Active Level Engagement with the Nursing Shortage…' (Cooksey et al., 2004)	This was another example of the use of data bases to collect information. This time it was used significantly to collect information of on a nursing shortage across five states in the USA.	
What Mental Health Services do Older AduIts Use…? (Hanrahan, 2002)	PhD Looking at deficiencies in workforce information making policy development difficult.	
'Nursing Minimum Data Set…' (Park & Delaney, 2003)	Not directly relevant to my research. Eight references that were found were more examples of medical uses of data linked by a Nursing Minimum Data Set.	

UK Long term Care Resident Assessment Instrument… (Challis et al., 2000)	Minimum data set assessment instrument. Consists of policy and practice backgrounds to assessment of needs and its application in the UK. Comparison of the MDS-HC with the current auditable methods in home care setting.	Relevant

All of the above material was read and considered and ultimately left out because my methodology was looking for key links to any or all of social care, workforce, or data collection. I determined most of these had no contribution to make because nothing was identified in the development of national data sets or data sets designed exclusively to collect and analyse workforce data. Other material was located specifically on the technical development of databases and, further, under the bracket of databases collecting evidence to aid clinical understandings (not on workforce) (Werley & Lang, 1988; Ryan et al., 1999). The HACC MDS (Home and Community Care Minimum Data Set) is now widely used around Australia, and a Google search in 2010 found over 7000 results relating to it. This was relevant purely because it was a database using the term 'minimum' data set in its title.

An Analysis of the Results of the Literature Search

The results of the literature search can be broadly summarised as follows.

- Information exists on minimum data sets used in clinical settings (Werley & Lang, 1988; Ryan et al., 1999). This does not have direct relevance for workforce planning but it proves data can be collected in a routine way. It shows that it is possible to create electronic health records outside the UK that may be shared across staff and used for planning.

- Studies of the workforce: (the largest number of articles and material), mainly make projections about the workforce with ideas about

retention. However, many are either small local studies from a long time ago (Kent County Council, 1993) or non-UK studies of limited relevance (from e.g. Australia, the USA) because social care is defined differently there.

- Studies explaining the concept of data warehousing: Kimball and Moss (2003 revising an earlier 1996 publication) discussed the development of data warehousing that would allow the ITC industry to make better decisions based on collecting better data. Graves (1998) discussed the use of data warehousing using the internet and intranets. This was interesting, because by the time the NMDS-SC was agreed it was clear that the internet was emerging as the strongest option for its development.

Developments Since 2006

Repeat searches in 2006 began to find references to the development of the NMDS-SC. Much of it came from Skills for Care and the DH. Reports of the Electronic Staff Record (ESR) within the NHS also began to appear, though - more often than not, focused on clinical development and staff patient record systems. Searches did not establish evidence that similar systems were being developed. By 2006 I had located 126 references to the NMDS-SC and over 400 that linked data sets and social care workforce. I was unable to locate any model I could copy or adopt.

Repeated Findings in 2010

Google is now established as a commonly used search engine. In January 2010 when searching the term NMDS, Google retrieved over 57,100 results specifically on the NMDS-SC. This had increased to 58,300 and 216,000 on NMDS alone by September 2011. This is indicative of the growth and establishment of the NMDS-SC as a national data source. The NMDS-SC has become the largest source of data on the adult social care workforce and is used widely today by researchers: include e.g. Hussein (2009b, c; 2010a, b, c, d, e, f, g, h; 2011a, b, c, d, e, f) as well as Rainbird et al. (2009) and Gospel (2009). Understandably, some of the hits on Google reflect Skills for Care documentation; however they also include uses by organisations like the CWDC, and Centre For Workforce Intelligence and government departments (DH, and Department of Education); and many social care providers who use the NMDS-SC have a web presence too. There are also the numerous training and support organisations that have developed business opportunities from supporting the completion of the NMDS-SC.

Conclusions

As Table 3 above demonstrates, I could find little of any relevance that had been written on the subject of collecting information on a large workforce in an agreed data set and keeping it in a data warehouse on the internet. I constructed some early diagrams of how this might work (see Appendix 18).

My research themes were workforce, social care and data collection. I never found anything resembling the NMDS-SC. I needed to understand the challenges

ahead and work out the strategy I would need to employ if I were to make any development successful, recognising the importance of carefully managing all aspects of this work. I knew it had to be a functional operation designed to meet the needs of those who had an interest and would use the system.

Certainly no ready-made model or solution was available or could be found in the literature. Much of what I found had no relevance (see Table 3), such as *Nursing Infomatics* (Goossen et al., 2000), or 'The Benefits of Implementing New Skin Care' (Bale et al., 2004). Even with the findings marked that had some link to social care, their links to the workforce were often only tangential.

I recognised that whatever was likely to succeed needed to have support and to incorporate people's needs and ideas, as well as probably being radical and new if it was to prove significant in benefit. On thinking about the data set I was keen to keep it small enough to be functional, and I initially thought of the top 20 items of information that social care needed to know about its workforce. Based around these formative thoughts, Chapter 5 discusses in detail the development of the NMDS-SC. I chose to use small case studies to develop 'early adopter or supporters' during trials of the NMDS-SC. These needed to be small enough to manage and yet demonstrate enough range to prove themselves as I progressed this work toward a full system.

CHAPTER 4: METHODS

In the writing of this thesis I have had to develop a greater understanding of some and a new understanding of many other theories and thinking. I have developed my knowledge and have learned to keep a good record of events relating to this thesis.

These are not typical social science theories as I am the developer of a solution. I needed to understand the implications for me, both subjectively and objectively, with all the advantages of knowing the field of work and stakeholders and my influence in the outcomes.

Case Studies

In writing this thesis, I have adopted a case study approach to build up the development of the NMDS-SC. This enabled me to study the process of collecting social care data as an integrated whole. As discussed in later chapters, the case studies of this thesis were developed in different phases, like the development of the NMDS-SC data set itself. This went through many stages of development and was tested out at each stage, such as the paper hard copies that went to 1000 employers in all regions of England, preceding the online NMDS-SC system.

Case study designs are helpful and informative when they help one understand the characteristics of such complex adaptive systems. A simple understanding of the mechanics of a large employer in the world of social care will do little to

highlight the need for better data without developing a more detailed insight into its relationship with the many organisations with which it deals.

Case studies are traditionally found to be useful when very little is known about a subject or phenomenon (Eisenhardt, 1989). The case study approach is appropriate for exploratory, descriptive or explanatory purposes (Yin, 2003). Case studies have been used to describe processes (Lawrence & Hardy, 1999), generate theory (Gioia & Thomas, 1996; Brown & Eisenhardt, 1997) and to test theory (Johnston et al., 1999; Sambamurthy & Zmud, 1999). Deciding whether or not to use case studies is not about how much research has been done, or how much is known about the phenomenon. The key is in understanding the research purpose.

A case study is an in-depth study of single individual, group or events. Case studies can include a mix of qualitative and quantitative evidence (Yin, 2008). Yin acknowledged that case studies can appear to lack range, because they focus on one phenomenon (Yin, 1993). The goal of the study should be to establish parameters. One study or 10 studies should not weaken the approach or the validity of the conclusions if this is remembered. In this way the NMDS-SC development is a case study and is not being directly compared or contrasted with any other innovation.

Snow and Anderson (cited in Feagin et al., 1991) pointed out that a case study may also be regarded as a triangulated research strategy, and asserted that triangulation can occur with data, investigators, theories, and even

methodologies. The need for triangulation arises from the need to confirm the validity of the processes. In case studies, this may be done by using multiple sources of data (Yin, 1994). The essential aspect in case studies is to establish meaning rather than location.

Yin (1993) identified five components of research design that are important for case studies. A case study's questions are most likely to be "how" and "why" questions. Their definition is the first task. The study's propositions sometimes derive from the "how" and "why" questions, and are helpful in focusing the study's goals. Not all studies need to have propositions. An exploratory study, rather than having propositions, would have a stated purpose or criteria on which the success will be judged. The unit of analysis defines what the case is. This could be groups, organisations or countries, but it is the primary unit of analysis. Linking the data to propositions and the criteria for interpreting the findings are the least developed aspects of case studies (Yin, 1994).

Case studies can be either single or multiple-case designs. Single cases are used to confirm or challenge a theory, or to represent a unique or extreme case (Yin, 1994). Single-case studies, such as this, are also ideal for revelatory cases where an observer may have access to a phenomenon that was previously inaccessible. Single-case designs require careful investigation to avoid misrepresentation and to maximize the investigator's access to the evidence. Yin (1994) asserted that a case study investigator must be able to operate as a senior investigator during the course of data collection, a role I was fortunately positioned in.

Case studies allow one to understand integrated systems, and complexity theory is a good support to this, focusing as it does on emerging patterns, their relationships and their comprehensiveness (Capra, 1996; Lee, 1997). Along with complexity theory, these provided a place to begin the significant task of determining how to improve data collection on the social care workforce and considering the social care sector as an integrated whole.

Social care is a complex matrix of relationships. In the simple form, there are those who use services and those who provide them. To add another layer, there are those who have an interest in the services provided (quasi-governmental). Furthermore, social care is not one homogeneous group of either providers or users. There are now over 40,000 individual organisations providing social care in England (Eborall et al., 2010). The vast majority of these are private and in business to make a profit, therefore in competition with each other; in reality they often have little or no link. I found it helpful to break down the aspects of the development of the NMDS-SC to appreciate these relationships and to construct three case sub-studies of different aspects of its development. The very route of deciding what the data set should comprise is one example, outlined as a case study. To understand this, complexity theory helps understand the competing relationships between 'organs' of the social care sector.

Theoretical Models

It was important that I develop my understanding and practice of reflection, something that went along with creating a space in my life to think critically, a

practice I increased over the period of writing this thesis. I was aware that over the last thirty years much has been written on examining reflection in professional work. My own background in social work and practice teaching had made me aware of the works of Kolb (1984), Schön (1987), Mezirow (1991, 1998), Eraut (1993, 1994) and Brookfield (1995), who have provided the theoretical underpinning of this thinking. In the profession of social work, reflection is recognized as an important element in practice, research and education (Yelloly & Henkel, 1995; Gould & Taylor, 1996; Bogo & Vayda, 1998; Evans, 1999; Martyn & Atkinson, 2000; Napier & Fook, 2000).

Tsang (2007) points out while stating the importance of critical reflection that there are many variations in how to do it. Brookfield (1995) proposes the use of four lenses by teachers: autobiographies; students' feedback; collegial discussions; and readings of literature. Evans (1999) makes similar suggestions in using critical incident analysis, a reflective diary/journal/log, and strengths, weaknesses, opportunities and threats (SWOT) analysis. This model was helpful throughout the development of the NMDS-SC and particularly used to determine risks as part of the project management (Osborne & Brown, 2005; Schwarber, 2009; Meredith & Mantel, 2011).

Mezirow (1991) was a leading thinker on Critical Reflection (CR), the state of thinking about an experience, a feeling, an event, an intention or a past action. He developed this further as the Critical Reflection of Assumptions (CRA), when the object of reflection is an assumption or presupposition. Mezirow further refined his thinking on Critical Reflection to also include the Critical Self

Reflection on an Assumption (CSRA), thinking about things one takes for granted. This was indeed relevant work in my challenge to improve what was known about the social care workforce. CR is sometimes termed the concept of 'learning to think for one's self' (Mezirow, 1998: p.15) and is something I grew to value as liberating and which I used increasingly throughout the scope of the project (Lawrence and Johnson, 1997). Building on the work of Mezirow, Mälkki (2010) discussed the importance of emotion and safe relationships, and inextricable factors for consideration when reflecting.

People I knew professionally and people I needed to make connections with were important considerations in developing this work. These were the key stakeholders that I will discuss in Chapter 5. I worked hard to recognise both the internal and external stakeholders and gatekeepers to understanding in reflecting and developing an analysis for this work.

Knowledge Management and Evidence-Based Practice

We develop research and gather evidence to tell us how we did what we did and how it might be improved the next time. We should always learn from success and failure (Williams & Glasby, 2010; Williams, 2011). The organisation I was working for had no previous experience in developing large and complex Information Technology and I intended to use my research capabilities while at King's College London to understand the pitfalls and the difficulties ahead while working out how to implement change (Barker & Cole, 2007; Paton et al., 2008).The more I could understand about what I was trying to develop and the characteristics that would help or hinder this work, the better I believed would

be the likely outcome. Knowledge management, says Williams (2011), is often underdeveloped. Organisations collect information but often fail to use the information or share the information. Williams called this the change from practices based on habit and custom to ones informed by best practice, a process of innovation and improvement (Williams, 2011: p.99).

Williams (2011: p.100) also argued that innovation and improvement should be seen as four processes of change; discovery, adoption, diffusion and routinisation. If information and knowledge are to change from a passive to a pro-active innovation to become standard over time, it is necessary to counter the 'it's what we have always done' syndrome (p.101). I and many stakeholders wanted the NMDS-SC to become routine.

The context often has relevance to the individuals and their specific remit and responsibility as decision makers. Is their innovation welcome or even recognised? Many organisations do things a certain way, 'because that is what they have always done'.

Rodgers (2003) talks of a 'Diffusion of Innovation' model; and Williams' (2011) discussion of the roles of different actors in social systems as innovators, early adopters, the early majority, the late majority and the laggards may be useful to this framework for considering the interaction of characteristics and individuals in the spectrum of change (Williams, 2011: p.103). Gaining a clearer picture in my mind of the different parts played by different stakeholders and organisations in the social care sector was useful as this thesis developed.

As part of this debate, Williams (2011) discusses the importance of Structure, Climate and Resources. I was positioned in a modern, 'receptive' organisation that saw itself as a learning organisation and had given me a department as a resource, a specialism and focus around social care workforce and a freedom to innovate as a senior manager. I had been supported to undertake the PhD and I knew in turn that this would offer me the research legacy I would need.

The NMDS-SC was built in a climate where organisations were receptive to new innovations and public investment was possible. I am very aware that currently (2012) the development of the NMDS-SC would likely never have happened irrespective of individual innovators and leaders (van Zwanenberg, 2009).

The premise of the NMDS-SC was to gather information, turn this into knowledge based on research, and feed this back into social care. Matheson (1995: p.74) referred to any system or process being designed to acquire, conserve, organise, display or retrieve and distribute what is known. I was at the front of driving the change that became the NMDS-SC, and so my leadership was critical (Dirks & Ferrin, 2002). Locock et al. (2001) describe the nurturing of leaders or 'improvement champions'. Fitzgerald (2002) distinguished three types of opinion leader: those who channel information across networks and organisations; those bestowed with expertise; and those with strategic management and political skills. On reflection I believe I straddled all three of these definitions at times; and, in common with most studies (noted in Williams, 2011: p.110) I effected most change through my leadership by using

my personal enthusiasm and a demonstration of commitment to innovation (Leeman et al., 2007; Oliver, 2007).

Stakeholder Theory

As discussed in Chapter 3, there are many stakeholders in social care, ranging from central and local government to employers and employees across the statutory, private and voluntary sector, pressure groups, unions, service users and carers, and groups advocating on behalf of service users and carers. This is why stakeholder theory was useful in this work.

Pinto and Rouhiainen have observed:

> *Past organisational research and indeed common sense tells us that organisations and even managers within those companies cannot operate in ways that ignore the external effects of their decisions.*
>
> (Pinto & Rouhiainen, 2001: p.143)

They stated furthermore that:

> *no manager makes decisions exclusive of the consideration of how those decisions will affect external groups.*
>
> (Dill, cited in Pinto & Rouhiainen, 2001: p.143)

External groups, or stakeholders, may be 'interveners' with the potential to threaten the completion of the project (Cleland, cited in Pinto & Rouhiainen, 2001: p.147).

The concept of stakeholder support emerged early on in my thinking about social care workforce data. Donaldson and Preston (1995) investigated

stakeholder theory, stating how some see it as a potential foundation for social science research, while others use it as a blanket term to group different perspectives, each based on their own personal situation. Jensen (2001), meanwhile, argued that managers should make decisions and take account of the interests of all stakeholders. In the case of this thesis, this includes employers, employees, customers, communities, civil servants and government.

I had no problems gaining access to various stakeholders. I was inside. I was known in the sector and had a national profile through my previous decade of work. I undertook what Coghlan (2003) called 'mechanistic-oriented action research', partly because I was looking at a pre-defined issue and increasingly recognised problem. This type of action research focuses on the researcher having the skills to work with client systems (Nielsen, 1994): for me, often the very stakeholders interested in this problem.

Government is an important stakeholder in social care. Government drives standards, government legislates for change, or government might adopt a more 'laissez faire' attitude, allowing the sector to self-govern. Most importantly it is government that provides much of the funding, through allocation of resources and through taxation. This funding also funds training.

Stakeholder theory is not clear on how the 'deals' between these factions should be managed, according to Jensen (2002). Each stakeholder has competing interests but it is up to managers to make purposeful decisions. Simply knowing that there are various interests does not help one to decide on the best course of

action. As Jensen pointed out, stakeholder theory can render a facilitator like me unsure of the rights and wrongs of a given situation. I had to remain sensitive to all interests. Jensen suggested that this theory might appeal to the self-interest of managers and directors.

I knew that to succeed I had to understand the main stakeholders who would have an interest in this work. I had to identify who might have something to lose or something to gain from its development. I knew there were internal stakeholders among the Skills for Care board members and senior managers, as well as external stakeholders such as employers. In defining the data set, I had to ask the sector's stakeholders for their input; however, stakeholder theory did not inform me how to achieve jointly desired outcomes.

Complexity Theory

Another useful framework for explaining the process of engagement and achieving ownership by different stakeholders whose views would be influential is that of complexity theory (Anderson et al., 2005), which highlights the potential for different directions and interests, as demonstrated by employers in this sector and also the different interests and demands for data. As previously discussed, the social care sector is not homogeneous, and this posed challenges in gaining support for this project: there were many factions to please (Mabin et al., 2001). Wherever possible I attended and spoke at conferences and in seminars around England in the service of the NMDS-SC: some early agendas from these events are in Appendix 19.

In considering social care employers and developing an understanding of stakeholders, both internal and external, as previously described, I have had to increase my understanding of the nature of difference in the sector. Complexity theory has been helpful in understanding this. Anderson et al. (2005) highlighted the different directions taken and varying interests that employers in the sector might have (Lawler & Bilson, 2010) .

Complexity theory provided me with some clues as to how I might address some of these dynamics. However, it was thinking about the NMDS-SC development as a case study that provided greater opportunities to make sense of it at several levels. Using it in planning the case studies and following them through has helped me understand this project holistically, rather than as a series of non-linked developments. An early mind map, designed in 2003, outlined the complexity of the social care system that needed to be understood and tackled collectively if change was ever going to materialise (see Appendix 1).

Complexity theory allows one to join up all related parts and see them as an interactive, relational whole, where each part has a symbiotic existence with the others. An individual employee working in social care is not a homogenous microcosm. Social care is made up of well over a million individuals' preference or dedication to the work, as well as others engaged in it briefly or for sporadic periods according to need. Employers in the sector are various, and their business objectives are complex.

As Merry observed, it is ‘a never ending process of change, which creates new order’, though self-organisation, self-creation and creativity (Merry, 1995: p.33). Why has it been so difficult to raise standards of care or to ensure that care practices comply with regulation of the sector? Complex systems are not just the sum of the number of those who make up the system of social care; any understanding has to factor in the differing relationships between them all. There are the many small providers who largely came into the business in the late 1980s and early 1990s to provide services that the state was then shedding, as described in Chapter 4. These providers are employers often in competition with each other and driven by profit. For many, their very existence is dependent on them making enough profit (Matosevic et al., 2011). Over time, many have failed and larger organisations have developed, providing corporate-style social care. Again, profit is a key variable here, but the size of the national and sometimes multi-national organisations allows profit in itself to be very complex in terms of equity income, capital and taxation (Forder & Fernandez, 2009). Over time, a range of interventions has occurred as employers may choose to invest or simply move their assets elsewhere in the economy (Forder & Fernandez, 2009), as recently demonstrated in the case of the care home company, Southern Cross, in 2011 (Hansard, 2011).

Case studies help us recognise complex adaptive systems and the previous chapters explain why social care can be seen as such. Anderson et al. (2005) detailed the key characteristics of a complex adaptive system:

- Agents. Human or other processes are at play: there are many interconnections; information exchanged, even at a local level, creates a global pattern, the effect of which is not limited and may have significant consequences.

- Self-organisations. The way people change according to circumstances and organisations are developed.

- Emergence. Non-linear interaction causes change to develop and new, previously unseen, properties to emerge.

Finally:

- Co-evolution. Everything interacts and changes continuously yet everything is intricately linked with its own history.

Complexity theory helped me understand interdependencies and interactions among the whole. Through a study of these variable interdependencies, understanding complexity and diversity brings a richer understanding to case studies.

Implementing Large IT Developments: The Design/Reality Gap

I was aware that implementing new technology systems could be risky. I too had read the media coverage of system failures and budget overspends. These issues of ITC systems failure were not limited by geography (Littlejohns et al., 2003) or in hospital information systems failures (Goldfinch, 2007).

Brendon Whittaker (2009), in a study conducted in Canada, outlined the three main reasons for failure as being:

1. Failure to plan adequately

2. A poor business case

3. A lack of support from key stakeholders and top management.

He indicated that 31% of IT projects were cancelled before completion and over half the projects researched cost an average of 189% of their original budget estimate (Whittaker, 2009).

Investment in IT systems has grown significantly as IT capability has increased since the mid-1990s. The UK government made unprecedented investment into health systems (Suhrcke et al., 2006). Despite what the then Health Secretary, Frank Dobson said, in the foreword to the Burns Report back in 1998, it appears little has changed:

> *Up to now the use of IT in the NHS has been not been a success, far from it. Lots of money has been wasted.*
>
> (NHS, 1998: p.3)

Other large ITC contractors had had problems, notably with ITC development in the NHS (Collins, 2010; Heath, 2010). Notable examples include the Care Records system. Implementation began in 2001 yet 10 years later, in 2011, it

was still not finished and had over-run its budget more than tenfold (Bloxham, 2008; Ballard, 2011).

I knew we had to build the social care system in an incremental way (see chapter 8). I read what Heeks (2005) had written about the 'Design-Reality gap'. These are the problems which arise when designs are followed from day one and builders and implementers fail to continually re-check their links throughout the build. I also knew we needed to select a system builder we knew we could develop a positive relationship with and who would work in the interest of the NMDS-SC and Skills for Care.

I knew I did not want the development of the NMDS-SC to become a media story for the wrong reasons. I directed effort from myself and colleagues in Skills for Care into the project management of the system and even more critically in ensuring that the NMDS-SC would be something the sector wanted and supported. Top-down initiatives and a lack of local engagement have been given as the main reasons systems fail (Bruce, 2011).

Any system that was developed had to be able to stand the test of time and still be valuable. It needed to change and to keep pace with new developments. I knew that the system would need to be able to withstand others taking a second and often more in-depth look at the data.

Validity and System Testing

There are various 'sophisticated' techniques used including mixed-effect models to account for the hierarchical effects of employers and personal

characteristics on pay levels: multinomial regression models to investigate the probabilities of working in different types of settings, such as adult day care; logistic regression models to investigate the profiling of specific groups of workers such as migrant workers or British BME workers (Hussein, 2011); linking the NMDS-SC data to local deprivation indices and rurality level to examine the effect of local unemployment, deprivation, urbanisation of the local area on the prevalence of volunteers in the sector.

Secondary Analysis of the NMDS-SC Data

Hussein has been leading the analysis of the NMDS-SC since August 2009, which marked the first publication of the series 'Social Care Workforce Periodicals' by the Social Care Workforce Research Unit at King's College London. This is an analysis of emerging quantitative workforce data, which has provided an evidence base of information relating specifically to the social care workforce in England. The series is the first in-depth analysis of what were then the latest versions of the National Minimum Data Set in Social Care (NMDS-SC). Hussein points out that the NMDS-SC is the first attempt to gather standardized workforce information for the social care sector.

Hussein and Manthorpe (2011, 2012) have also, for the first time, constructed longitudinal data analyses from nearly 20 NMDS-SC data sets to examine changes over time among same groups of providers, looking at longitudinal changes in care worker turnover and vacancy rates, and reasons for leaving jobs, among the same group of providers from 2008-2010.

Hussein also pointed out that the NMDS-SC has provided the sector with a unique data set, providing information on a number of workforce characteristics for the first time. She offered a note of caution highlighting the emerging nature of the NMDS-SC, largely because the data has not as at 2011, been completed by all the adult social care employers in England and thus she suggested that some of the findings may be under- or over-represented. Furthermore, she commented that as data are entered by employers and not employees this may result in some bias.

In her report on NMDS-SC establishment files, Hussein (2009b) noted the potential to examine the numbers of staff working in different job roles in different sectors. This analysis facilitated an examination of the vacancy rates and turnover rates by job role. Hussein calculated the net-flow rates and compared these between different job roles and types of establishment. Combining these statistics enabled a better understanding of the flow and movement of workers in different jobs in contrasting parts of the social care sector and enabled the readers to understand the pattern of new recruits and the loss of existing workers during the past year. Hussein suggests the current economic downturn may be affecting social care work in a number of ways, perhaps causing workers to stay in social care offers stable employment.

In issue 16 of the SCWP, Hussein (2011c) used 'Bayesian modelling' techniques (Cogdon, 2006). These are used to estimate the percentage of workers likely to be paid under the national minimum wage, using different data sources including the NMDS-SC, adjusted by data from the Unit's longitudinal care

study. The model used prior estimates already developed by the Low Pay Commission and the ONS to estimate a 'posterior' distribution of the probability of direct care workers to be paid under the National Minimum Wage.

Chapter Summary

Throughout this thesis I have drawn upon all of the theories discussed in this chapter. The above section illustrates the 'practice' of use of the NMDS-SC. These theories, and this example of analysis in action, have helped me plan, learn and increasingly understand the many factors at play in trying to achieve the change I had in mind. The following chapters chart the journey in time until the release of the live NMDS-SC online system in 2007 as detailed in the timeline in Appendix 3.

CHAPTER 5: DEVELOPING WORKFORCE INTELLIGENCE IN SOCIAL CARE AND ACHIEVING OWNERSHIP OF THE NMDS-SC IN THE SECTOR

Introduction

In Chapter 2, I discussed the complexity and size of the social care sector. Chapter 3 considered the literature (or lack of it) on developing a solution to improve workforce data such as the NMDS-SC. These considerations set the context for this chapter, which explains the process of establishing the solution and gaining support to establish an operational NMDS-SC- online system. Without this process of stakeholder engagement and consultation about what data should be collected, it would have been impossible to reach the stage where policymakers and the sector were committed to establishing the NMDS-SC online. My first 'green light' was, as mentioned, being given the support of the DH to solve a problem. Skills for Care supported me in focusing on this issue of poor social care workforce information and in spending time thinking of solutions to improve it. My first task was to consult social care stakeholders about what information on social care they needed. From that came the versions of the data set that finally became the NMDS-SC online.

Social care stakeholders can often change their interests and allegiances. As well as the employers and government there are significant miscellaneous organisations like the Learning and Skills Council (LSC) (in 2005) and of course the NHS. Stakeholders raise their profile and their interest at different times. This depends on their own organisational position and interests and the

significance of what they can offer and more often what they can get out of participation. Equally the economic climate of the time or the knowledge they possess would determine their involvement in any initiative. Most of the organisations in social care are service delivery organisations and most of these are not structured to sustain involvement in policy or workforce reform. The difficulty for considering the options to research for the best way of improving social care data collections was getting and keeping them interested and persuading them to play an active part. Marketing language calls this 'keeping them sticky' or maintaining their interest (Zheng & Yang, 2011).

There is no doubt in my mind that my own profile, personality and familiarity helped me from the inside. Data collection and data sets were for some exciting and others less so. The choice of being involved in this became easier as I began to make headway and the work gained profile and presence. Being involved had some kudos. Some could not afford not to be involved and partake in the development of data collection. In most instances, constituency or member organisations expected to be involved in some manner.

Identification of Key Stakeholders

There were two pre-requisites to the development of a data set that comprised all the information that the sector needed: who or what is the social care sector, and what data does it want to be collected? How could I establish even-handedness in designing and establishing this data set, for a sector that consists of more than a million employees and tens of thousands of employers?

From my working knowledge of the sector, I knew that there were many networks operating in social care. Many of the associations and interest groups representing private sector employers are members of the boards of national organisations, such as Skills for Care, the Sector Skills Council, where they operate alongside government departments and professional bodies.

Other organisations with interests in the development of workforce information in social care included the Association for Real Change and the Social Care Employers Consortium. In the statutory sector, organisations include the LGA (Local Government Association) and the NHS Employers' Organisation. Professional bodies and staff representation organisations include the Association of Directors of Adult Social Services (ADASS), British Association of Social Workers (BASW), Learn to Care, and the Trades Union Congress. Organisations for people who use services include People First and Carers UK. The sector also includes Further Education and Higher Education: such as, Joint Universities Council/Social Work Education Committee and Further Education: Association of Care Training and Assessment Networks.

Social care also has a number of important interest groups representing employers who are their members, such as the National Care Forum, the UK Home Care Alliance, the English Community Care Association, the Registered Nursing Home Association, National Council for Voluntary Organisations, Employers' National Care Association and the Social Care Association. Many providers belong to one of these groups and pay an annual fee. Indeed, there are more than 20 organisations acting as employer groups in social care. Some of

these are national, and some are local or regional. In addition, there are cross-sector employer representatives, such as the Federation for Small Businesses or the Association of Small Businesses. However, none of these organisations have majority membership of employers in the sector. Relatively speaking, these organisations, or others in the sector, operate through a comparatively small membership, in relation to the total number of employers within the sector. Many small social care employers do not belong to any lobby or support group. These organisations were my first points of call to locate individuals that had an interest in the development I was embarking on. The problem remained, as noted, that only a small percentage of social care employers participate in any sector strategic bodies. Most social care employers either find it hard to make the time to participate as stakeholders in committees or local and regional social care groups, or they simply choose not to do so. Of course, it may also be the case that some have not been asked. The end result is that a select few dominate the sector and claim to be the definitive voice of social care.

As a Sector Skills Council in England for all social care (although from April 2006 it was to cover only adult care, following the establishment of the Children's Workforce Development Council), Skills for Care could not expect or want to have a personal dialogue with all sector employers. It needed to establish a customer base. A selection of key strategic organisations was required and I had to find a vehicle to engage employers on a manageable scale.

I needed to engage people on at least two levels. The first was at the level of strategic planning; the second, as part of a consultation on the level of detail

necessary in the data set (Barker & Cole, 2007; Nelson, 2007). In deciding who to involve and how, I needed initially to bring together a group of people with an interest in social care and its workforce (Henderson, 2010). This could be a local, regional or national interest. My concern was that the people convened would be at a high enough level to contribute to a dialogue about what information, not currently available, was required about the social care workforce.

I still believe that some in my own organisation, Skills for Care, never really expected me to succeed and certainly did not recognise the value of what I was working on until very late in the day. However, I was given a pivotal role to attempt to find a solution and I grasped it firmly. At the point I was beginning to get somewhere, Skills for Care leaders had begun to realise that I had become central to this development. Skills for Care realised it was in its interest to support me and to ensure the development stayed within its organisation. My own research and work with KCL had allowed me distance and time for reflection, which sustained me over this period.

As mentioned the development of the NMDS-SC online involved the following as key stakeholders: the Departments of Health (Social Care), Education and Skills (its title in 2005); Social Care Institute for Excellence; Children's Workforce Development Council (from 2005); Learning and Skills Council; General Social Care Council; the NHS, through its National Workforce Programme (2005); and the Commission for Social Care Inspection (in 2006). All were key delivery organisations or government bodies. The independent sector was represented

through such bodies as: the Registered Nursing Home Association; Federation for Small Businesses; National Council for Voluntary Childcare Organisation; UK Home Care Association; Employers National Care Association. LAs were represented via the Local Government Association; Local Government Analysis & Research (LGAR); Local Government Employers (LGE) (in 2006) and the Association of Directors of Social Services (in 2005). I required the support of all these groups. They had of course different interests and demands and it was necessary to understand and be aware of these (Cleland, 2008; Meredith & Mantel, 2011). I worked for Skills for Care and had to satisfy its interests. I had some interest and encouragement from the DH to make a difference in how the social care workforce was understood and, since these were the funders of Skills for Care, this support could and did prove crucial.

At first consideration, the development of the NMDS-SC was a task that required some explanation. Why had it never been done before? Why had it taken so long? What is hard about setting up something so apparently simple? These are all questions that were posed by observers. Simply describing the whole project without pulling it apart is difficult. What are the characteristics of developing the NMDS-SC that enable it to be seen as a system and not something else (Clark, 1999; Cafer & Misra, 2009; Wysocki, 2009; Ince & Griffiths, 2011)? To consider the question, I continued with further examination of the external environments and Skills for Care stakeholders.

A good knowledge of, and years of experience in, the sector had enabled me to understand why there is only intermittent progress in many areas. Much of the

development work has been difficult with slow progress. Not until a contract was signed for the main system development at the beginning of January 2007 did I believe the work was becoming a success. The social care sector became committed though its commitment to investment.

The lack of uniformity of either employer or any community always meant that gathering democratic weight behind this project would be difficult. Two of the few constants have been the absence of any data and secondly, the desire to gather better data to improve planning. This was consistently supported by internal stakeholders on the SRI project board, especially from the DH (representing government). It was less than reciprocated at times by Skills for Care's own board, and some of its members' apparent lack of willingness to link the employer receipt of Training Support Initiative (which is funded by central government) to completion of the NMDS-SC.

Interestingly, very few people ever argued against the need to improve data collection or the quality of data to be collected. The main source of contention was the collection would require individuals, employers and organisations to do something extra: they had to complete the paperwork. Even though all agreed it was a good idea to collect it at a macro level, employers, government and service users all saw being asked to contribute data as an imposition. During the development of the NMDS-SC, it was smaller employers who were the hardest group to locate and to engage. My experience has been that once they have been located and communications begun, smaller employers have largely found the project positive for them and have undertaken to complete the data. Larger

employers have usually been the easiest to locate but the hardest to persuade: for them, as with so many employers, it takes a significant effort.

Arguing for completion of the NMDS-SC is like arguing that smoking is bad for you. Very few argue against this. The hard part is to stop smoking. When it came to completing the NMDS-SC, employers resisted and refrained from completion, as described in Chapter 5. Understanding why this was the case may be made easier through considering complexity theory and seeing the sector in all its organic, living variables (Capra, 2002).

This has provided a conundrum, as the coalition government found in its attempts to reduce public sector spending. We know that social care is required at some level or other. But what is the level that is required, and how can government encourage or even legislate for this costly commodity whose largest asset is its workforce? Models that focus on incentive to change can be made more complex by trying to understand those who never interact (McDaniel et al., 2003).

There is a paradox in the relationship between those who provide services (the employers) who are too busy delivering services to be involved in policy development, those who deliver the services (the employees), those who demand a standard and a level of service (government, on behalf of society) and the stakeholder and delivery organisations mentioned earlier. As discussed in Chapter 4, complexity theory helped me understand this further. Government sets standards and has a finite budget according to political and economic

variables. Services can vary according to social conditions and culture. An ageing UK population will demand more social care in some format (Taylor, 2009). Yet, an increasingly mobile society with smaller and simpler family units is unlikely to swing back to provision of care within the family. Someone has to care for disabled and older people, and someone has to pay for this care. The care may change from institutional to personal provision through Direct Payments, but professional or paid care is likely to prevail. Standards of expected care are progressive, and there are no indicators that suggest a lowering of standards is likely or desirable. Employers demand profit, yet society declines to pay more through taxes. We do know that those undertaking work in social care are often being paid less by than the National Minimum Wage (Hussein, 2011c). Such dilemmas faced the independent Commission for the Funding of Long-Term Care, who wrestled with the challenge of finding solutions for the expected growth in demand for social care in the future (DH, 2010b).

In summary, stakeholder perspectives are competing. Government and the sector need to know more about the workforce in order to plan and develop the most effective and economic system of social care. Social care as a sector has a seemingly insatiable demand for greater funding from government and expenditure on it has grown until recently (Mahesh et al., 2011). Organisation and individuals during the development of the NMDS-SC were all keen to support anything that might increase their revenues. Equally, many were unhappy to be seen as clear objectors in case this affected their funding in some

way. I recall a few people at conferences telling me they were sceptical of 'big brother' information gathering by way of the NMDS-SC. The DH sometimes appeared reticent about demanding statutory data completion, as it might lose the goodwill of employers, and seemed wary of increasing regulatory demands (DH, 2011a). The recent demise of the GSCC is an example of this. The GSCC never succeeded in registering the whole social care workforce. Change, therefore, walks a tightrope (Cameron & Green, 2004/2009; Blomquist et al., 2010).

Employers who fund improvements that are too expensive risk failing and leaving the sector, as profit margins may not be maintained. A smaller voluntary sector and informal care could not fill this vacuum. Yet without better intelligence, government cannot plan or even begin to understand the resources in place or be confident the sector is fit for purpose.

Involving Key Stakeholders

I decided to bring together an initial group of interested and experienced people from the sector to start work on what data should be collected on behalf of Skills for Care. I located individuals that I thought were interested, and who I thought would have something valuable to say about what a social care national minimum data set would look like. I decided that the first step would be to invite them to a meeting and compiled an agenda in order to stimulate discussion. This first meeting was held at King's College London in 2004, partly because at the time Skills for Care did not have any London premises and also to give the meeting some status and repute by association. From that first meeting

of a large group, I sought volunteers for a smaller, more functional 'technical' group to work on the development of the data set (Kerzner, 2009; Wysoki, 2011). The technical group would spend more time debating the detail of the data required and the choices of what to include and what to leave out, while keeping it small enough to operate. The constituent data items were then firmed up to a state to generate national discussion. Those events that defined the final structure and content of the NMDS-SC would be further tested out later in trials with employers, as explained in the following chapter.

Establishment of Regional Conferences

My first task after this initial meeting was the development of a working draft of the NMDS-SC, building on the first draft discussed in the meeting held at King's College London. A series of drafts was presented to the sector at a series of regional conferences and seminars, in the winter of 2004-2005 in London, Bristol and Leeds (see Appendices 5 and 6). These conferences provided a forum for strategic discussion and incorporated small, more informal workshops where detailed queries could be raised.

I spoke at conferences for employers and other stakeholders, launching the idea of the NMDS-SC. The DH and SCIE, as well as the Social Care Workforce Research Unit, sent representatives as speakers, covering the need to develop better information on the social care workforce, speaking in the morning at each conference. In the afternoon, participants had an opportunity (through workshops) to look in more detail at the draft proposals and express their thoughts, so that these might be addressed in further developments.

Interestingly, not one person at any of these events said they were opposed to the development of the NMDS-SC. Quite the contrary. There was a good deal of positive support. For example, one attendee wrote to me: 'A truly excellent idea but the practicalities of collection, storage and access to information are complex and must not be allowed to let it down' (personal communication). Another said: 'Everyone is signed up to the need for NMDS-SC, the concept is good, the devil will be in the detail!' The group's greatest scepticism was around getting the social care sector to participate fully. The notes from these events, including feedback from individual workshops, other comments made during the seminars, and feedback obtained after the seminars were synthesised after the event and are summarised in the table in Appendix 6.

Deciding Which Data Should Be Collected and How

Collecting social care data on the workforce involved employers having to think about which data should be collected. This, for many, may have been a question they had never contemplated before. However, through the conferences, hundreds of employers and interested stakeholders from social care contributed to populating the prototypes with data items they thought were important (Appendix 7). This was hard work but ultimately a fruitful exercise. The strap-line 'collect once, use many times' was coined early in developing the NMDS-SC. Over the years many employers had mentioned that they had too many forms to complete. Random surveys, local and regional demands for information were commonly seen as a drain on their time. The NMDS-SC idea was marketed as a 'one-stop shop' for data, for both employers and those with a

need for the data. It was developed and 'sold' as collecting the data they wanted. The process above was their contribution to what went into the data set.

It became more apparent that three clear issues were emerging. As feedback and information from the conference informed me, many employers were concerned about the a) potential burden of completion b) the issue of data security and c) the issue of confidentiality. As will be explained later, this was one reason for not including names or personal details on the NMDS-SC but instead just using National Insurance Numbers (NINo). A NINo is automatically issued to every UK citizen before her or his 16th birthday, and an individual retains the same unique number throughout his or her life. Other people, such as those moving to live and work in the UK, apply for a NINo through Job Centre Plus. While it is known that a small number of duplicates (Hansard, 2007) and fraudulent (Hansard, 2009) NINos have been issued, for the most part, possession of an individual's NINo remains an accurate way of identifying a person and avoiding double counting. Because the prevalence of part time working in social care is so high, it is estimated that many social care workers have more than one job to increase their overall earnings (Eborall & Griffiths, 2008; Hussein, 2011c). This risk of double counting was therefore an important consideration in the development of data collection and a threat to reliability we needed to resolve.

The NMDS-SC had always planned to use the NINo only once, for the generation of a unique identification number that would be encrypted and not visible as an

output once entered. This explanation has been important to ensure employers have complete confidence in the data security of the system.

Most of the main items in the data set were not contentious (see Appendix 7) and people attending the conferences and from feedback during discussions agreed with the vast majority of data items that had been developed at three conferences (see Appendix 6). There were only a small number of exceptions; namely whether the data set would ask employees how much they were paid and the inclusion of the NINo. There was considerable discussion to achieve agreement, and the final NMDS-SC both included the NINo and asked employers how much they paid their staff.

The initial draft was revised many times. Data arising from the three conferences were then further refined to take into account comments and representations. The conferences' main points were brought to a smaller, internal, Skills for Care group to work into a final data set for use, called the Technical Data Group of Topss Workforce Intelligence. Further work continued across 2006 to ensure that data items were reliable and valid and the tool being developed meant the same to a wide range of people. The NMDS-SC online would be secure and reliable and I, through Skills for Care, made great effort to create the correct requirements for its development (see chapter 8). Moreover the establishment of a change control group with an independent chairperson, to consider future changes and the development of the NMDS-SC data set over time was established to ensure the longevity of the development.

Refinements focused on:

- Potential uses being listed and responses being developed in increasing detail.
- Confidentiality, access and data protection rules.
- Developing guidance in documents and handbooks and online help.
- 'What's in it for Me' statements were created, where possible written on single sides of A4 paper, for social care employers and employees who need to complete the NMDS-SC.
- Making decisions about the use of the NiNo as the best unique identifier for the data set. Agreement to use this was obtained from the Data Protection Commissioner.
- Writing agreements and governance.
- Devising questions in plain English.
- Developing protocols for change.
- Developing final versions of the questionnaire and formats for the software.

By March 2005 I had reached a near-final draft version, and the arrival of the NMDS-SC was announced at the then Association of Directors of Social Services conference in Birmingham in October 2005. This was a high-profile event but it was also recognised that more work was needed before the NMDS-SC could be

operational. The solution had to be built and successfully marketed to the sector.

Technology is continually advancing (Brock, 2006; Microsoft, 2010; Mahesh et al., 2011). Throughout the writing of this thesis the internet's availability and its use increased exponentially (see Chapter 3). It had become clear that the NMDS-SC would be an online system and resource, allowing completion online now that technology would allow this. It was recognised that, having announced its arrival to the sector, it would be sensible to keep the momentum going. To do this a middle-ground solution needed to be developed; one that would make use of the work so far in advance of the complete NMDS-SC online solution being procured. The data set and the practicalities of completing it had to be further trialled and tested. This task was in itself complex. This first real version was piloted in the sector and described in Chapter 6.

Learning from Other Data Sets

In 2003, while working for Topss England, I made links with the NHS electronic staff record development. I knew that very little work had gone on anywhere on workforce data sets (see Chapter 3). The NHS was pioneering developments for its own project to link staff records with pay roll for its workforce. It became apparent to me that those running this process wanted to know more about the social care workforce, but came from a strong NHS background and knew little about social care. A large database was being developed for the NHS staff that appeared to have few or no relevant fields or variables for the range of people

working in social care. I decided it would be necessary to develop a data set specifically for the social care workforce.

To minimise duplication, once development of the NMDS-SC was underway, in late 2004, efforts were made to ensure synchronisation to developments in the National Workforce Intelligence Policy Program (NWIPP) in the NHS. NWIPP however ceased in August 2004, moving into the National Workforce Programme (NWP). With some interested and experienced social care employers and organisational members of the Topss Workforce Intelligence Unit, a technical group was established in September 2004 to develop the data set further and link it to the work of the NHS in the NWP. Revisions continued toward the final version that went live on the online NMDS-SC in 2007.

Role of Internal and National Stakeholders

Having held a series of conferences and discussed what data would be collected and how, the next stage in the development of the NMDS-SC was to confirm and reinforce the commitment of internal and national stakeholders. At least one senior leader in Skills for Care told me they saw very little chance of it ever coming to fruition. I felt I needed to improve understanding of the nature and aims of the NMDS-SC at this level. In contrast, I had good support from the DH (the funder of Skills for Care), whose civil servants were quick to recognise the potential of this data collection. I received consistent support from them throughout the development of the NMDS-SC.

Government, in particular the DH, could have decided to compel employers to contribute such data on a mandatory basis, but I was told personally by the DH that this was politically unpalatable. UK research on whether making something mandatory result in a comprehensive and quality response, is thin. Voluntary programmes in environmental issues had a higher response than compulsory ones (Wu & Babcock, 1999) and it made little difference in financial returns, with voluntary returns showing a slight improvement (Butler et al., 2007). In a study of compulsory wearing of seat belts in excess 90% of drivers were found to comply (Ashton et al., 1983).

I got the impression that there was an assumption within the DH that if this project was successful, there was an opportunity for social care nationally and the DH, as supporters of the project, to benefit. Alternatively, if it failed, government would not be held or seen to be responsible. Resources and concrete support were to be debated much later, once I had demonstrated the potential of the NMDS-SC, and prepared much of the groundwork.

Through much effort and a great deal of liaison, developing contacts between structural bodies in the social care sector and government departments, the NMDS-SC emerged. The new organisational partnership structures were committed for the first time to 'joined-up' working to gain improved information on the social care workforce. The NMDS-SC data set was developed to be compatible with the NHS Electronic Staff Record.

Once the data set was agreed, practical solutions for its collection were established with a framework and budget that were likely to be achieved. Support then appeared to grow. In 2006 there came a tipping point when this project began moving of its own accord, as enough people on the steering group and technical group understood the project and believed in its importance. These people supported me in influencing Skills for Care to express its commitment to the project. The final tipping point was not reached until Skills for Care itself supported the NMDS-SC, which involved persuading the CEO and the Board that this would benefit Skills for Care significantly in the future.

The Process of Engaging Stakeholders in Skills for Care

On reflection, I realise now that I had worked hard to enlist the support of stakeholders through operational involvement, regular meetings and updates; but I had probably failed most in keeping my own senior managers involved and included, and therefore broken a basic rule of project management (Humber, 2004). Discussions I have had with some of those senior staff recently, informed me that they didn't feel uninformed as much as they were too busy to take any real notice under pressure of their own responsibilities. Published literature on stakeholder theory, discussed in Chapter 4, had shown me the importance of gaining stakeholders' support; and I developed my own skills in recognising and procuring important stakeholders, including the DH Minister at the time (see Appendix 15) (see Chapter 4). I knew who was important to the success of this project. I had developed my own skills in project management through 'Prince2' (Bentley, 2005) training project

management training. As mentioned earlier, I was in a unique position to develop this idea and provide a solution to the challenge I had been given, to improve social care workforce information. The idea, the stakeholders and the solution were all developing but most senior people in the organisation did not take a lot of notice or were too busy with their own responsibilities. Perhaps I could or should have been more inclusive?

While all the key players and external stakeholders (to Skills for Care) were keen on this development, some internal stakeholders were less than enthusiastic. At the November 2006 Skills for Care Board meeting, support was almost lost for its procurement (Skills for Care, 2006). This was the first Board meeting of the new Skills for Care Chair, whom I had briefed prior to the meeting, and who saw the potential of the NMDS-SC. In my view, there was a new drive from Skills for Care as the Sector Skills Council, which should be clear about what it did, and require strong clear projects to be developed as part of the organisational brand. Other Board members who were involved in chairing this project's groups also influenced Skills for Care's decision to give it full backing. This work thus suited the requirement that Skills for Care needed strong, nationally-influential projects.

In November 2006, the key decision moment arrived. I had to stand up and make what I am told was a very passionate argument, even though I believed the idea did not have the support of all at Skills for Care. I persuaded the Chairman and the Skills for Care Board to back the project to move to its next stage, and they agreed to support it financially. Things moved smoothly and in

January 2007 full support manifested itself in the signing of the contract for the electronic system, at a cost of around £5 million, with funding provided to Skills for Care from the DH. This helped Skills for Care focus its attention and ensure commitment. This was the stage at which I felt the project had become more certain. A further approach to the DH led to additional funding of £2 million for capital investment in the work.

Achieving Compliance

Completing NMDS-SC is not mandatory in England. It is designed to support employers to meet the National Minimum Standards for the sector, and is 'marketed' by Skills for Care as such. The current regulator, the Care Quality Commission (CQC), encourages employers to complete the NMDS-SC and take its information directly from the NMDS-SC data prior to inspections:

> *The single page report allows CQC registered employers to download AQAA workforce information from NMDS-SC Online to provide the workforce element of their AQAA return to CQC when requested. In addition, the NMDS-SC has proved vital to the CQC in helping them understand the wider sector and features in their annual reports. The NMDS-SC also has the potential to help CQC monitor providers' ongoing compliance with registration regulations and support quality improvements for all regulated activities.*
>
> (Skills for Care, 2009d: p.3)

Given the scepticism shown by some in Skills for Care about actually getting employers to complete the NMDS-SC, the real challenge in assuring success came from marketing and persuading employers to complete the data set. Some

work had to be done to combine the Training Support Implementation (TSI) grant to employers and link it to the NMDS-SC. The aim was to encourage employers to complete the NMDS-SC. This was a critical lever as it ensured that this money, distributed to all employers in England by Skills for Care, was linked to the completion of the NMDS-SC. Skills for Care has continued to make the completion or refreshing of NMDS-SC data a requirement in order to claim funding. This also includes full completion of worker records for a minimum of 90% of your total workforce. To be eligible, the following three criteria must be met:

1. An establishment which has completed an NMDS-SC organisational record and fully updated its organisational data.

2. The establishment must fully complete individual NMDS-SC worker records for a minimum of 90% of its total workforce (this includes any staff who are not care-providing).

3. Individual records for workers completed which are included in the 90% calculation must be both fully completed and updated.

This guidance was given online to define the criteria and explain how compliance would be checked (Skills for Care, 2011b).

A series of three 'What's in it for Me' guides were produced at Skills for Care and used in marketing (see Appendix 12). This supported the NMDS-SC development and established it in the minds of stakeholders. Two important indicators of national government support for the NMDS-SC occurred in 2006, with the release of a video in which the then Minister for Health, Liam Byrne MP, appeared. The video also included many other key strategic stakeholders

explaining why they supported the NMDS-SC. I decided early on that enlisting the Minister and other key organisations 'leading lights' on video would be a public statement that would give the development of the NMDS-SC a high profile. This part of the project was hard work for my colleagues and me. I believed that once the Minister was on record as supporting the NMDS-SC it would create a 'snowball' effect (Bachrach, 1971; Drafke, 2006; Savage, 2010). I had put some scripts together for the DH civil servants to convey to the Minister. Filming was set up at DH headquarters, Richmond House, and the Minister held his notes on a small prompt card in his hand. I think the recording worked because the Minister was confident and clear that social care needed better information and the NMDS-SC was possibly the only *radical* way to gain this.

I also had to decide whom else I would approach as prime individuals, who had some power and position in social care, to join the Minister in the video. I knew if I could find enough high-profile individuals to support the project, this would in turn give the project a stronger profile, especially once their support was caught on camera. I encouraged people to participate by telling them who else was involved, and hoped that they would not want to be left out (Kelley, 1976; Wilson, 1992; Grint, 2005). This worked as all the people I approached took part in the video. I considered whom I could rely on for support and balanced that with those whom I needed for the video. The participants in the video were all sector-wide stakeholders, well-known in what is a small circle of influential people in social care.

I called first of all on those who were involved in the governance of the NMDS-SC through the Skills, Research and Intelligence SRI Board in Skills for Care. I did not manage to get everyone to participate but I enlisted key personnel from DfES, the NHS, and local government, along with strong interest groups from the private and voluntary sector. Where I could not get people along to a low-budget limited filming, I managed to get quotes, from organisations including CSCI, the GSCC and the Wanless team then working for the King's Fund. I managed (with difficulty) to persuade government to contribute money for these developments (via Skills for Care) throughout. I even gained additional funding from the NHS to support the links we were making with their own data needs in social care.

The second development occurred when David Behan, who had been appointed the first Director of Social Care at the DH, spoke at the Skills for Care North East conference in January 2007. He said that the NMDS-SC 'will bring social care information gathering into the 21st century - and is an essential development.' This comment was recognised as demonstrating support from national government to modernise what social care knew about its workforce through the NMDS-SC project. Taken together, these events were key building blocks in achieving the acceptance of this data collection vehicle.

Establishing a Project Board

In developing links in the sector, analysing them, and using the links in Skills for Care, I took account of the wide range of social care stakeholders and made connections between them. Acknowledging that there can be tension between

sponsors, such as the DH and GSCC (which are national, policy-driving organisations), and employer and service provider stakeholders, a balance was struck in selecting the membership of the Board. I personally chose, met and discussed membership with all the Workforce Intelligence Board and technical group members (Appendix 13).

As sponsors of Skills for Care, the DH was keen to improve information on the workforce. Emergent challenges that had to be considered were that most employers are small or medium sized enterprises and have no real time or interest to engage in this development. As noted in Chapter 2, most are in direct competition with each other and are isolated and disconnected from the sector as a whole.

Skills for Care needed to make decisions about the stakeholders who could play an interactive part in this development. As mentioned earlier, I made a conscious effort to pursue people significant in the social care sector, ensuring they would join and be active members of the SRI project management Board. I knew it was critical to enlist individuals with expertise and experience. My selected chairperson was a member of the Skills for Care Board, who was representing the LGA. Getting him to support this work was a monumental achievement. The important role of the chair was to oversee my work and advise me on the direction I was taking. He was also able to offer boundless support, especially good political advice. He had excellent contacts across the social care sector, having operated at a high level for many years. He was able to bring all that experience to support me. It was essential that the chairperson

was a strategic thinker with an understanding of the full scope of the task. Once again, a broad range of organisations in the sector was invited and representatives from employer and stakeholder organisations joined the Board.

The identification and recognition of internal (Skills for Care) and external stakeholders was a key distinction in understanding any analysis of this work. Both these factions had different interests and demands on the project. As Appendix 13 illustrates, the initial group changed from the SCWFTG into the WFI steering group for Skills for Care. The technical group worked in parallel to undertake more detailed work on the product.

Discussion

This chapter has explored elements of the process of implementation of the NMDS-SC. The chapter has described the process of identifying and achieving stakeholder agreement. It has identified the need to gain support from both internal and external stakeholders in the successful implementation of any project. Through the process of identifying stakeholders and holding a series of conferences, it has shown how information gathering is a two way process, in which the expertise of the sector and the data it provides was used to identify the best way of obtaining information from the sector. This chapter has illustrated the necessity of identifying 'product champions' who can be used to exert pressure in support of an initiative. It highlighted the role of policy levers, in the form of financial support from national government, as an alternative to statutory regulations. In the next chapter, I will detail as a case study the three different employers who piloted the NMDS-SC and the results. Chapters 7 and 8

will then detail the move of the NMDS-SC from a temporary long-hand, paper exercise, to the electronic version, and then to the online electronic system.

CHAPTER 6: LESSONS LEARNED FROM THREE SUB-STUDIES UNDERTAKEN IN THE DEVELOPMENT OF THE NMDS-SC

Introduction

This chapter reports three important sub-studies that were undertaken in order to develop the NMDS-SC. These are used to illustrate different aspects of the project's implementation.

The first study considers data collected by the National Care Standards Commission (in 2009 the successor of this inspectorate became part of the Care Quality Commission) as part of its inspection process. The NCSC needed to investigate if the inspectors already possessed information or had the potential to undertake, with little disruption, the collection of information that would make the development of the NMDS-SC unnecessary.

The second study piloted a version (with a fairly stable data set, after many revisions) of the NMDS-SC, with a sample of employers designed to give a good spread in terms of geography, size, and sector. This was to investigate whether this version of the NMDS-SC would be feasible and could deliver the information required.

The third study was the complex exploration of the processes of attracting the LAs and significant organisations, such as the DH and inspectors, as supporters and users of the NMDS-SC. This study continued the exploration of the process of seeking support as described in Chapter 5. It focused on external support. It was necessary to establish the benefits for potential supporters and a successful

method by which they could be included. This had to be a system that worked, giving them something that most of them did not have. If it was possible to make their interaction as practical and seamless as possible then that would be ideal. Finally, I wanted to demonstrate that their engagement in the NMDS-SC would enable them to gain a better understanding of their workforce, both at individual establishment level and in their locality or area of work. This is discussed further in the concluding chapter to this thesis, Chapter 9, which refers to the development of InLAWS using data collected nationally in the NMDS-SC 2009-10. This present chapter, then, takes forward some of the themes discussed in the previous chapter to illustrate how careful piloting and stakeholder engagement were essential preliminaries to the establishment of the NMDS-SC.

Background

As discussed in Chapter 3, the notion of a data set meaning a collection of specific data items for any particular purpose was becoming more common with the advancement of database technology. Though the purposes of specific data sets may differ, the facility to collect data according to data fields as specified has clear benefits for data analysis. It offers the ability to collect consistent non-variable data items. It offers the ability to collect and analyse the data longitudinally through time, knowing that data sets keep their integrity. Within large data collections there is always the risk that data changes or becomes corrupt. The establishment of an agreed data set reduces this risk, but does, nevertheless, need to be carefully managed.

As mentioned in Chapter 2, there is no clear definition of what the social care sector comprises. Social care overlaps with health, housing and other public spheres. It is also complicated by internal divisions between Adults and Children's sectors, politically determined at different times. The social care workforce is not self-defining. For the most part, it is defined as those who work delivering social care. The Children Act 2004 required local social services in England to create the post of children's services director. This meant that social services, which originally combined the responsibility for children's and adults' social care, devolved into children's services, aligned with education, and adult services, aligned typically with health. The data set was simultaneously developed to include questions on children's organisations. Politics then played a part and with the arrival of CWDC, other data collections solutions were considered for a while by this body. Eventually CWDC returned to supporting NMDS-SC online collecting data (CWDC, 2008).

The First Study – Using Data Collected by Social Care Regulators

The first study was designed to answer the following question: did the regulator (then the NCSC) collect information as part of its inspection process that could give the sector the workforce data it required? It was known that inspectors asked for workforce information as part of their process of inspecting care providers, under the Care Standards Act 2000. Before that date, the independent care sector had been regulated by a fragmented system of local scrutiny by LAs and health authorities (Gage et al., 2009). Introduced in response to the recommendations of the Royal Commission on Long Term Care

in 1999, the Care Standards Act 2000 established the NCSC in England as the independent regulatory body responsible for inspecting and regulating almost all forms of residential and domiciliary care, including care provided by LAs themselves. Established in 2002, the NCSC was replaced in April 2004 by two separate organisations, the Commission for Social Care Inspection (CSCI) and the Commission for Healthcare Audit and Inspection (CHAI), generally referred to as the Healthcare Commission. In April 2009, these two bodies were in turn replaced by the Care Quality Commission (CQC), which is currently (2012) exclusively responsible for the inspection, monitoring and regulation of health and social care in England.

It appeared that it would be possible to answer the question, whether inspection data fulfilled the needs of the sector in terms of information about its workforce, by undertaking a short case study in one area, which could be seen as representative nationally.

Changes to the regulator had implications for the study. Permissions had to be granted and protocols agreed to allow external access to this confidential information. This took four months. Early developments with the NCSC had been progressing well prior to April 2004. At this point, the new CSCI suspended negotiations but, eventually, agreement for the project to go ahead was reached through a memorandum of agreement between the CSCI, the DH and Topss England. A report was taken to the CSCI board in 2004, outlining the remit of the proposed pilot study for their approval. This was agreed and the study went ahead.

The study took place at an NCSC office in the west of England. This location was chosen because it was large enough to cover a number of providers and was thought to be of a suitable size, and to offer a broad range in terms of the type of providers it regulated. The intention was that the study would provide a picture that could be extrapolated to the rest of the country. Methods included my personal scrutiny of inspection records to determine how much information they contained on each institution's workforce. Individual records on each care home were entered into a new data file exactly as they were recorded, so that it was possible to quantify exactly what data were collected and consider the quality of the data in terms of accuracy and the number of missing values.

Four significant findings emerged, which were reported in a discussion paper from King's College London (Evans et al., 2004). Firstly, the proportion of missing data items was too high for the data to be useable. Secondly, there were too many codes being used for items like 'job role' or 'reason for leaving'. These needed to be refined in order for the data set to be of use. Thirdly, the individual worker level data was more complete than the care home level data, suggesting that individual level data were easier both to collect and to use. Fourthly, it was clear that, in practice, an organisation such as the CSCI could collect data through their inspection process. The addition of an agreed set of minimum data items, with clear and understandable codes, could be added into this process in order to produce data that could be compared with other sets collected using the same minimum data set framework.

Through the NCSC study, we established what data the inspectors were collecting about the workforce and enquired as to their needs for further data. It is important to the development of data collection in this sector that double counting does not take place, for example many workers have two jobs. The development of a system that could provide triangulation of data items to ensure each unit of data was applicable to only one person (i.e., that details of one particular employee were not entered twice, through two different means) would be very important (Patton, 2002). Triangulation and certainty of data was achieved by ensuring each person on the system was checked against their NiNo, their postcode and their date of birth. This ensured we had a unique individual. With a growing number of instances in social care and health where identity fraud has occurred and the need to be clear that the data are clean and of a high quality, this was essential.

All areas of the UK can be broken down by postcode. Within the nine regions of Skills for Care in England (in 2007) this was equally possible. Each region could be measured against the success it was having engaging employers and their staff to complete the NMDS-SC data. Some regions started more slowly than others (see Figure 1 in Chapter 7).

The Second Study - Testing out the NMDS-SC: Three Pilot Studies

By 2005, the NMDS-SC had been through a number of revisions. The data items had been agreed following the three national conferences described in Chapter 5, and had been refined further. It was now time to test the system on employers. It was essential that data could be standardised, the NMDS-SC

questions had to be clear and written in plain English. Responses to questions had to be achievable to expected variables, covering all the potential options (Schwab, 2005). The system would not allow any free text, as part of the standardising process. Drop down menus and multiple choice questions would ensure responses enhanced the opportunities to gather volumes of clean data, encouraging those completing to answer all the questions required (Kimball, 2004). We also had to make sure the system was easy to use and navigate. Data had to be fit for its intended use and of a quality to be analysed. At the same time work was underway to determine what analysis should be standard from the software. Over and above any analysis that Skills for Care and others would in time wish to undertake on a secondary level (Thomson & Walker, 2010; Hussein, 2009-11), it was important that questions were asked and answers given to deliver consistency and completeness (Patton, 2002) across the data because of the expected high volumes. Completion on paper was taking between 20-50 minutes, dependent largely upon support given, in the pilots. The online system eventually brought this down to an average of 12 minutes.

We decided to trial the NMDS-SC in three sub-regions of England. It was recognised that the trial would be significantly more useful if it could be readily generalized: so it was important for the sub-regions to have different characteristics, and to contain a broad selection of types of social care employers: smaller and larger, as well as those in the independent sector and those run by local government. This pilot process was conducted in spring 2005, to test the gathering of the data and its potential for analysis. I visited

each of the sites several times during the pilots, at the start and the end and a couple of times each during the process, to link with the local managers.

The pilot studies began with the selection of a range of potential pilot locations from the contacts who had taken part in developing the data set to a functional version. Introduction and guidance to the NMDS-SC and the aims of the pilot were given when three volunteer social care providers for the pilot met in London in February 2005, before the pilots began. A second meeting was held mid-study (April 2005) and a final event in June 2005 discussed the learning from the pilots.

Invitations seeking volunteers were sent out, with the explanation that the NMDS-SC was designed to provide an agreed and standardised basis for data collection across the social care sector, to ensure comparability of data. The invitation explained that Skills for Care intended to improve the quality of information collected, to make data widely available to the organisations that need it and to save employers from having to complete multiple requests for information.

The aims of the pilots were to test out the latest version of the NMDS-SC in a questionnaire and to use it in the three sites. Their variety was an essential element because ultimately the NMDS-SC would need to be completed by thousands of widely differing employers based in many locations. The purpose of the pilot study was to explore how the NMDS-SC could best be collected from small and medium-sized enterprises (SMEs), who are the main providers of

social care. Two questionnaires and one form incorporating all the data elements and written in plain English were designed, with SMEs in mind, from version 12 of the NMDS-SC.

It was clearly stated that the NMDS-SC would be collected and held in accordance with the Data Protection Act (1998). In time it was planned that individual employers would be able to access and make use of their own data. Otherwise all data would be available only in an aggregated and anonymous format, and individual staff would never be identifiable other than by their own employers. Local, regional and national organisations were expected to be able to obtain reports about different levels of data, according to their needs. It was envisaged that employers would be able to benchmark or compare themselves against anonymous data from others in their area. LAs would also be able to analyse this data in their area.

The pilot areas were self-selecting employer stakeholders contacted though the Skills for Care Skills Research and Intelligence programme Board and technical group, an explanation of their membership is included in Chapter 5 and detailed in Appendix 13. It was essential that each of these different locations participating in the pilot, although different from each other by nature, would use the same structure to report their experiences.

Larger care providers, LA social services departments, and the NHS were not excluded from the pilot study, but in the end only a few of these bodies participated. Three Skills for Care regions in separate geographical areas (North

East London, Berkshire and Staffordshire) volunteered to conduct the pilot study among social care providers in their areas. We had to rely on their selection of social care providers to participate in the study, as the employers were regional contacts. This ran the risk that each Skills for Care region would use a slightly different approach to recruiting volunteer employers; something which did indeed transpire, with North East London and Berkshire primarily linking into existing projects, while Staffordshire developed a different approach and gained a broader sample of providers.

The North East London area covered seven London boroughs and was conducted by the North East London Workforce Development Confederation of the NHS. A total of 88 providers were contacted and asked if they would participate in this trial. Of that number, 64 (73%) completed the data collection either fully or in part. Berkshire built upon a European Social Fund brokerage project (BARCH) to invite 27 providers of social care to participate. Of that number, 19 (70%) agreed. Staffordshire, though an employer's consortium, included two LAs, contacting 98 providers. 34 of them (38%) undertook completion of the NMDS-SC.

Thus, each pilot site undertook a slightly different approach to selecting which providers would participate in the pilot. A report was produced to summarise the main findings from the three pilots and the implications for collecting the NMDS-SC (Skills for Care, 2005).

Key Findings and their Implications

As anticipated, employers wanted to know how they would benefit from completing the NMDS-SC. This became the catalyst for developing the 'What's in it for Me' series of documents, referred to in the previous chapter (Appendix 12).

Data cleanliness and functionality were not the only concerns (see Chapter 4). Getting people to complete the documentation electronically or on paper was always going to be a test. The pilots showed that where someone from Skills for Care personally met with employers and supported them to complete the NMDS-SC, then the completion rate was greater than if they did not. This demonstrated the need to develop regional support for and liaison with local employers to encourage completion. Where links were already well established - through training or funding partnerships that backed the pilot - completion rates were good. This demonstrated that the advance engagement of employers in the purpose and benefits of data collection improved response rates.

The pilots revealed that employers knew little of Skills for Care, and that Skills for Care would need to develop a marketing and communication strategy about the NMDS-SC to educate employers about it, in order to persuade them to complete it.

Later when we had a 'demo' online system a development that we were able to undertake was a partnership with Age Concern on a travelling buses project. This was a well publicised development where Skills for Care used four buses

from Help the Aged. The buses were filled with online technology and they went around to local employers all over the country. The idea was to help employers get into the NMDS-SC while at the same time helping employers who needed support with using computers and the internet. It was a success, although it was only funded for a few months. It encouraged and supported a lot of employers to become part of the NMDS-SC Online.

The pilots also demonstrated that providers of social care had more knowledge of inspectors than of Skills for Care, and that if the NMDS-SC was ever to be universally completed across the sector, inspectors would have to support the NMDS-SC and support the 'complete once and use many times' concept developed to encourage employer compliance. Initially, CSCI attempted to retrieve some workforce data via the NMDS-SC. Many technical difficulties arose, making the process cumbersome and inefficient. Because of this, CSCI and Skills for Care agreed that from 2007/2008, CSCI would retrieve all the workforce data needed for inspection purposes directly from providers via its Annual Quality Assurance Assessment (AQAA).

I recognised that gathering the NMDS-SC data would be influenced by the interest inspectors had in encouraging employers to complete their NMDS-SC. This support could then contribute to a virtual 'stick' without actual (and unlikely) legislation to compel employers to complete it.

ADASS support for the NMDS-SC

Following discussions about the NMDS-SC, the ADASS Workforce Development Committee meeting on 1st June 2007 made the following recommendations to ADASS members:

- ADASS fully supports the implementation of the NMDS-SC and recognises its potential for the sector.
- ADASS recommends that NMDS-SC information is collected at team or establishment level.
- That NMDS-SC 'Establishment Profile Reports' from the independent sector should be used as part of the commissioning process (to provide senior managers with a profile of the social care sector in their constituency including capacity, staff numbers and qualifications, retention and vacancy rates).
- The implementation of the NMDS-SC in adult service settings will take an incremental approach. Support for individual directorates is available from Skills for Care.
- The launch of the NMDS-SC Online will enable employers from across the sector to update, amend and maintain their workforce information in a secure environment which meets data protection issues raised about the security of information.

- Skills for Care is developing a tool that will enable bulk uploading of information from existing HR systems. This tool will become available to large employers in January 2008, being in the consultation and design phase, and will be tested during November and December 2007. This allows large employers to use already collected data applicable to populate the NMDS-SC once treated.

- The NMDS-SC will provide critical information at a local, regional and national level, enabling Directors of Adult Services to access information about the social care sector.

- ADASS should issue guidance for all LAs on data protection and the NMDS-SC, supporting the use of the NINO and seeking views on appropriate interpretation of the Data Protection Act with regard to whether opting in and out is necessary.

(ADASS, 2007)

The pilots took place long before the electronic vision of the NMDS-SC was available to demonstrate to employers. Understandably, paper submission was therefore preferred. It was also a time when IT ability and the availability of broadband and the internet were increasing (BBC Online, 2006; Czernich et al., 2011). The then e-minister Steven Timms MP spoke at the CMI (Cambridge and Massachusetts Information Technology) Institute annual conference in November 2003, saying: 'today I am calling for us to take the next major step and deliver broadband availability to every community by the end of 2005'. This

would also demonstrate government commitment toward e-government, as stated in the White Paper *Modernising Government* (Prime Minister & Cabinet Office, 1999). So, for the foreseeable future, a number of manual methods of completing the NMDS-SC had to be available. Challenges with lack of individual worker literacy and basic skills problems in the social care workforce were recognised through the pilots (Skills for Care, 2005). Feedback from the conferences held to discuss the NMDS-SC showed that employers were sceptical that the NMDS-SC would supersede all other data collection. Skills for Care would have to work in partnership with ADSS and CSCI to ensure they understood that other forms of workforce data collection would end, leaving the NMDS-SC to stand alone. As mentioned previously, my work with the GSCC to link the NMDS-SC to registration proposals, ultimately never went beyond the planning stage. The subsequent demise of the SSD001 (EO) and the Delivery Improvement Statement (DIS), planned by the DH, supported this effort.

Employers shared their concern about confidentiality issues and the use of the NINo. Skills for Care and the DH learned that they would have to assure employers that the use of the NINo would be confidential and would not be seen by Skills for Care as part of data collection through encryption, but simply used as a quality cornerstone of data triangulation. Further doubts about what this data was required for, and general data protection issues, were concerns for many employers. Skills for Care would have to find ways to reassure employers about data security and also to confirm the need for and uses of the information. As a result of this work it was appreciated that the development of guidance

from regional and national Skills for Care, by way of handbooks, marketing and proposed outputs, would have to all be carefully undertaken. As the new Sector Skills Council, Skills for Care still needed to promote itself and show how any data given to it would be used for the benefit of the social care sector. Named data protection officers in Skills for Care and an independent person with governance of the data set would all need to be appointed.

Detailed Findings from the Pilot Schemes

The pilots revealed individual employees' reluctance to complete the data submission process. The need to focus on organisations and employers in a first phase of data collection became the proposed solution. This was developed in the knowledge that any emerging electronic solution would have to make the capture of information easier and the differentiation of employee and employer data less obvious and less difficult for employers. It was recognised that some employers preferred to complete the NMDS-SC on behalf of their employees. I concluded that this was probably the most feasible option, and that employees would, in most cases, never interact with the NMDS-SC. Permissions for employers to enter data on behalf of their employees would have to be designed.

The pilots allayed employers' anxieties that the LAs might be used as conduits to collect data that might be commercially sensitive. The level of competition in the sector between care providers emerged in the pilots and a lack of trust in LAs was expressed. More specifically, other challenges emerged from the pilots. These included the problems such as the fact that domiciliary care providers

often did not calculate staffing on the number of people employed but calculated on the basis of the number of hours worked.

The multiple job titles in social care also needed attention, if employers were to complete the NMDS-SC in any meaningful way. The development of a 'Job Roles' booklet to accompany the NMDS-SC documentation would subsequently go some way towards resolving this problem. This booklet was developed in 2006. The use of the NINo would also ensure that people were single counted in this complex sector. At this point, the collection of information about Criminal Records Bureau checks was being considered for inclusion in the NMDS-SC. It proved so contentious it was subsequently removed from the data set.

Findings from the three sites

The pilot study concluded that the NMDS-SC was most likely to be completed when there were obvious direct benefits for those completing it. It was clear that employers would not spend time completing the questionnaire unless there were tangible benefits for them. It was also clear from the pilots that where support was given then employers would be more likely to complete the NMDS-SC. This support could be in the form of an outreach worker, who could provide added value with support around funding or training and development plans for staff. A good example was in Berkshire, where small and medium sized enterprises (SMEs) became involved through their participation in the pilot European Social Fund-funded brokerage project. They complied with completion of the NMDS-SC because it was incorporated into the Training Needs Analysis (TNA) required for the brokerage project, and they therefore

knew what they had to gain from completing the return. This area had very high levels of completion. A similar situation emerged in the North East London pilot, which also achieved good completion rates.

In other LAs there was no obvious direct benefit for employers in completing the NMDS-SC return, and accordingly pilots encountered a marked reluctance to provide the information. This is where an improved 'What's in it for Me' marketing strategy became recognized as essential if the NMDS-SC was to succeed. The North East London pilot offered an incentive to some providers, providing a CD-ROM that contained Investors in People (IiP) software with workforce development guidance. IiP has a recognised status attached to it, which is another incentive. The software gave providers the opportunity to seek IiP status, recognised as a potential 'hook' to obtaining greater completion.

In contrast, in Staffordshire, where a broader range of social care providers participated, no 'funding carrot' or incentive was incorporated. The initial reaction to a first, unannounced, 'cold' mailing of the questionnaires and accompanying explanatory letter was very poor. Only four returns were received, of which three were incomplete. In order to gain a better response, those assisting Skills for Care in Staffordshire had to invest a great deal of time into follow up and support, assistance and advice. This was usually undertaken through visits from two full-time outreach workers, but still the final response rate was only 36%, around half of that achieved by other two pilots. Moreover, Skills for Care in Staffordshire had to invest more resources than the other two pilots to achieve this less satisfactory result, with 40 full working days being

spent on managing the pilot, through collecting supporting and encouraging employers to complete the NMDS-SC questionnaire.

As mentioned earlier no LA social services department participated in the pilot in full, although 10 LA care providers in North East London and three in Berkshire participated. Here, the authorities were partners in the training needs projects. Reasons for not participating included a lack of resources and time, being otherwise focused on other issues such as the Gershon review of efficiencies (Gershon, 2004), and the need to complete the CSCI's Delivery and Improvement Statement. A consistent problem raised by LAs was that the required data were usually being held in more than one place. This is a factor that the later LA embedding project had to bear in mind.

No large organisation in North East London was asked to complete the NMDS-SC. In Staffordshire a large care provider was contacted, passed it on to its head office, and nothing further was heard.

In Berkshire nine members of the network were approached and five completed the pilot. These organisations were cautious, and claimed the benefits from completion were not obvious, as they already had HR departments that kept records and could give them information on their workforce.

Practical Problems in the Pilots

It has been claimed that IT skills (and other basic skills) are lacking in the social care sector, especially among smaller independent providers (Skills for Care,

2007a). This was borne out by the pilot studies, as few of the participating organisations used or claimed they had access to computer systems at the time. Paper questionnaires were preferred and were used in the majority of pilot study returns. Even in organisations where computers were available, few of the managers chose to complete the Excel spreadsheet available as an all-staff form. They chose instead to use individual paper questionnaires, even though this was a significantly more time-consuming process. This may have been because of their lack of confidence in using such a system. The all-staff grid was rejected, because managers said it looked “off-putting” and “scary” on paper. This was one document to include all their staff details. A great deal of photocopying of employee questionnaires took place.

Managers were asked either to complete the employee data or to get it completed by asking employees to do it personally. Most managers understood this as meaning that the employee questionnaire needed to be completed by employees. As a result, managers spent far more time chasing employees to fill in their part of the questionnaire than would have been taken up in just filling it in on their behalf. Understandably, managers saw this as a problem, and something they did not like or necessarily want to do as part of their work. This also resulted in many incomplete forms, as some employees found the form too difficult and only completed the few mandatory questions. In contrast, where managers chose to complete it themselves on behalf of their staff, as in the Staffordshire pilot, this raised questions about the reliability of information, and why managers did not want employees to complete it themselves. The London

pilot team asked if there was in fact a need for a separate employee questionnaire, if employers could complete it themselves.

Skills for Care was told by staff working in the pilots that employees seemed reluctant to complete their part as it was too complex and took too much effort. Some were also reported as seeing it as intrusive and personal, especially in asking about topics like pay, ethnic group and the request for the NINo, even though the NINo could be expected to be in employer's personnel records. In contrast, employees were happy to complete questions on training and qualifications. They were reported as seeing the questionnaire as too official and off-putting. It seemed that Skills for Care was going to have to put a great deal of effort into explaining the questions clearly, in order to ensure that people answered them properly (Torangeau & Ting, 2007). The pilots exposed some confusion amongst respondents.

As mentioned we knew, confidentiality and data protection were concerns raised by employers. These echoed concerns expressed at the national conferences, as discussed in the previous chapter. In some instances, people thought the information had already been collected by others. There was also a widespread failure to understand the questions, and some employees needed help and support in completing their returns. The reason for this was thought to be a poor level of basic skills and/or having English as a second language. Where this was the problem, employees needed someone to sit with them and help fill it in. In Staffordshire, a creative employer developed a training tool to

support staff with problems with basic skills, incorporating the NMDS-SC questionnaire.

It was clear from the above findings that simply asking people to complete the NMDS-SC on its own would not achieve comprehensive completion. We needed to link completion to direct benefits for employers if we were to succeed. We had to find ways of giving them added value, exposing the link between completion and other beneficial rewards they would appreciate.

The scope of a project is critical and how change occurs has to be carefully managed to avoid 'project creep' (Lawrence and Johnson, 1997). Stakeholders have to own the system as developed: resistance has to be removed through careful testing and in doing so increasing and ensuring support and functionality (Wastel et al., 2009; Pithouse, 2010). The challenge in all project management is how little or how much. This applies particularly to complex systems. Getting the balance right is critical. 'All organisations are a design structure of some sort. Too little risks anarchy and too much brings bureaucratic sclerosis.' (Wastell et al., 2009: p.1). Scope is discussed further in the next chapter.

Linking completion to training benefits or access to funding, along with clearly developing the options, gave employers a tool for workforce planning. All these proved positive encouragements in the pilot studies. Where dedicated support was given in the data collection process, completion levels were high. Support was provided by personal contact from outreach workers who linked with

provider organisations. These outreach workers could explain the NMDS-SC, give help to complete it and provide support on other subjects like training, workforce planning and IiP.

Where an organisation had been part of a pre-existing partnership with established working relationships, completion by employers was good. This was also the case where employers were supported by a local employer network. Where Skills for Care had positive links with the CSCI, this appeared to create strong conditions for completion. We realised from the pilots that effective marketing and a strong communication strategy to promote Skills for Care and raise awareness of the NMDS-SC prior to launch would be essential. A practical lesson from the pilot was that for the foreseeable future we would have to rely on the availability of paper-based data collection methods for the NMDS-SC. This was due to low internet availability and use among social care providers and also the lack of a useable electronic version of the NMDS-SC.

Need for Automation

The pilot studies revealed several factors that discouraged participation. Among these was the very basic issue of the time it took social care providers to complete the forms. If thousands of employers were to provide their information, we would have to make the process more efficient. This confirmed the need to automate the process, putting it online.

We would have to be more precise about the list of benefits that employers would gain from completion. Employers, particularly in larger establishments

and social service departments reported that the information that the NMDS-SC required was often held in different parts of their organisation. This key importance of the balance of functionality and a fit for purpose system were recognised as failing in the Integrated Children's System (ICS) with the sad and brutal death of 'Baby P' in Haringey in August 2007. The inadequacies of the system clearly contributed. A Guardian article, 'Child Protection Stifled by £30m Computer System' (Booth & Stratton, 2008: p.7) commented on the issue, and child protection issues and the ICS failings were also noted by others (Cever et al., 2008; Pithouse, 2010; Ince & Griffiths, 2011).

I recognised that the promotion of the NMDS-SC would have to be made at the highest level of organisations, to ensure that they would support the NMDS-SC. I knew that Skills for Care had to gain support in the sector.

Avoiding double counting

At a more technical level, a solution to overcome double-counting of people being employed doing several different tasks over the working week emerged. We also recognised that we had to market the benefits of the information for which organisations were being asked about where their staff were recruited from, and where they went when they left their jobs.

Dealing with sensitive data

Testing out the NMDS-SC in the pilot studies, the employee questionnaire raised the thorny issue of getting NINo information from employees. Employers recognised this could be a means of identification and we had to persuade them

that it would never be seen or used, and that it was only an internal system tool to differentiate data. Some managers were concerned that employing temporary staff or staff from outside the UK might expose them to the risk of prosecution if these individuals were not permitted to work. We also knew from government that there were forged duplications of NINos. This was a problem that clearly needed to be dealt with, and consequently, in May 2004, government increased demands on employers to ask for further proof of ID over and above a P45 or P60, to establish a greater certainty of identification (UK Border Agency, 2010).

> *Until 2004 it was sufficient for an employee to have an official document bearing a National Insurance number, such as a P45, P60 or a National Insurance number card. Since May 1, 2004, employers have been required to ask for further proof, outlined by the Home Office on the website employingmigrantworkers.org.uk.*
>
> (Coates, 2006: p.6)

Collecting data about CRB checks had proved a problem in the three pilot areas, and CRB data had been removed from the Berkshire pilot. This piece of information was so controversial that we had to decide if it was an essential aspect of the NMDS-SC data set. A decision was taken by the project board that it was not essential, and could therefore be cut. Criminal Records Bureau (CRB) checks had been recently established (2002). It proved too contentious with employers. Employers were not keen on data being available that would identify what percentage of their staff had CRB checks. CRB checking was usually a cost they had to absorb. At the time of writing (2012) it has not been

considered by the Skills for Care NMDS-SC Data User Group. Information on ethnic origin is rich and has produced such reports by Hussein and others through secondary analysis allowing social care to be clearer about this changing aspect of its workforce (Hussein, 2009c).

Further work had to be done on questions about pay. Induction training and other qualifications questions needed re-working. Social care needed to know the gender of its workforce and the ethnic origin. We knew that social care was employing greater numbers of migrants but social care had little idea how many. 'Gender' was a word some employees were not familiar with, and the sensitive matter of asking about ethnic origin had to be thought through. Finally, we had to ensure the legality of handling information about staff as individuals. We chose to make all information about individuals anonymous, and make it visible only to the employers (who held the information anyway) and no one else. This would allow us to benefit from all the data on the sector while giving employers the potential of a detailed HR record system.

Lessons from the pilots

It was concluded from the pilots that marketing and communication had to become much stronger and more centralised. If these tasks were left solely to the individual or region then variations would occur. I had to ensure that the Skills Research and Intelligence team centralised the process and ensured a common standard was adopted for all NMDS-SC marketing and communications work. It was necessary to expand knowledge and awareness of the NMDS-SC within Skills for Care, and at Board and senior management level.

Documentation on 'Frequently Asked Questions' (Appendix 10), 'What's in it for Me' (Appendix 12) from all perspectives, and a good website were required. It was decided to commission a video for use on the Skills for Care website explaining the story of the NMDS-SC, its use and how it would benefit employers (Appendix 16). This would enable employers to see how it might improve their businesses through improved knowledge, strategic planning and IiP. It would include contact details and support to employers both regionally and nationally.

The qualities that employers must possess to gain IiP status are positive (Investors in People UK, 2007). On the other hand, employers who have engaged with the NMDS-SC also stand to benefit. Much of the focus on the aspects of being a good employer that the award of IiP demands is also part of the process of completion of the NMDS-SC. In turn, once employers are included and are participants in the NMDS-SC they are able to use it for human resource management purposes and as a tool for their organisation to benefit from, including gaining IiP status. They gain an instant and accessible accurate profile of their workforce. This, combined with the knowledge gained through its completion, can allow employers to improve their staff turnover, a persistent problem for employers in social care. They gain accurate picture of their staffing, and through investment, can improve the stock of skills in their organisation. This level of insight may allow employers to make the transition from less informed to more informed and 'better' employers.

As mentioned in the previous chapter, we also began to explore the possibility of Skills for Care regions linking the completion of the NMDS-SC into funding to promote IT skills and to support small businesses.

A still considerable amount of social care is commissioned through LAs. It had been suggested that because they have contractual relationships with most social care providers, LAs could act as collectors of NMDS-SC data from independent sector employers in their areas. This could enable LAs to use their local knowledge to collect the NMDS-SC from providers, some of which would be unique to a local area. The use of Skills for Care regional and sub-regional groups to promote data collection had many of the same benefits. Strategically, this information, gathered by employers and fed into local decision-making funding bodies, allows employers to meet the needs of government. This is through completing their own improved human resource data through both inspection and to meet National Minimum Standards (NMS). The provision of support enhanced the opportunity for some to gain ESF money, as outlined in the Berkshire pilot. By their inclusion in the pilot of the NMDS-SC, the gathering of this data put the sector in a good position with a rich vein of data. This was confirmed by a senior manager from the LSC in the Berkshire pilot study area, who wrote:

> *Where DIS (Delivery Improvement Statements) returns are good - workforce intelligence is good - where DIS returns are poor workforce intelligence will stay poor. If we always do what we have always done we will always get what we have always got.*
>
> (Skills for Care, 2005: p.4)

The Delivery Improvement Statement was linked to the CSCI Inspection process and was a return from providers that contributed to their star rating.

However, the pilot studies suggested that collection by LAs would be problematic for two reasons. First, data protection safeguards would make it hard for LAs to pass information to Skills for Care. Likewise, Business Link, a national organisation with the purpose of supporting small and medium employers, could not share its information. If an LA collected data from local providers, it might want to use NMDS-SC information to make decisions about the care providers to which it awarded contracts based on the NMDS-SC (for example, sickness levels). LAs were concerned that this would mean providers were unlikely to pass it to them in the first place. However, in Chapter 8, I discuss how LAs are using aggregated but anonymised information gained through the NMDS-SC to understand their current workforce and service provision in their geographical area of responsibility to plan for the future.

Secondly, limited LA resources were highlighted. LAs were judged to be unlikely to have the extra resources to collect and manage such information, particularly since they do not cover the entire independent sector. However, LAs would be perhaps the best route to accessing information relating to direct payments and personal budgets in the future (DH, 2007b).

Progressing from the Pilot Studies

The information from the pilot studies facilitated decisions about the development of the NMDS-SC. There were a number of clear points.

Employers had to be shown good reasons to make the effort to complete the NMDS-SC. Simply knowing they were contributing data for the betterment of social care in the future was unlikely in most cases to be reason enough. Skills for Care would have to be explicit about the reasons and benefits for completion, including the reasons for collecting information on aspects of employment they may not cover, such as asking them to report where they recruit their workforce from, and employee leaver destinations.

More than one version of the paper data collection instrument would be needed, as one universal form would not meet everyone's needs at this stage. Also, employers needed to be able to report their training requirements, as this was a pathway to both improvement and funding allocation. Skills for Care also had to find a way to help employers use their NMDS-SC data. Simply giving them back their data would in many cases not be enough.

Additionally, obtaining data from individuals was still problematic. A decision to concentrate on the organisational information and support employers to gather employee data at a second phase was taken by the Programme Board in 2006, following my direction. I prioritised getting employers to sign up for the system and getting their details into it. I knew that the vision of an online system through which they could enter their employee data would soon be available.

I believed that building relationships was the most fruitful pathway to collection. Skills for Care knew it had to bolster support in the regions and place the collection of the NMDS-SC at the heart of Skills for Care activity. Skills for

Care was starting to understand the power it could gain based on holding quality workforce information. It knew it had to be explicit and clear to all employers and employees about why it was collecting the data agreed.

It was evident from the pilot studies that employer partnerships (existing between organisations and LAs) could play a supporting role in collecting the NMDS-SC. When they were present in the pilots, they were very powerful. The position of Skills for Care, as a Sector Skills Council, was central and needed to be utilized to the full. In regions where good relationships existed through brokerage or business structures to deliver training and development needs for that area, then information was likely to be needed, and good support to complete the NMDS-SC appeared to be enough. In turn, brokerages and employer networks would be able to furnish employers with support tailored to the specific needs identified from their data. In doing this, it was imperative that Skills for Care forged strong relationships with funding bodies, such as the Learning Skills Council (LSC), which shared an interest in better data on this sector. In turn, the information collected would prove to have a direct local connection and funding decisions could be made against this new and potentially significant information. Wherever possible I believed organisations such as the LSC and Business Link could support employers in collecting and completing the information required.

Further benefits could be gained from employers by them linking into local planning processes and contributing towards the development of comprehensive data leading to increased investment. This would happen as

focused investment led toward improvements in service delivery over time, which should ultimately benefit service provision. This will be increasingly important as resources for social care become scarcer at times of economic recession or even simply greater demand (see Chapter 2), when resources have to be used efficiently. Experience from the pilots suggested that this potential to use information to manage social care better would improve relationships with commissioners of social care, and the inspection arm would grow in confidence as a better picture of social care emerged.

The Third Pilot - LA Embedding Project

LAs in England are the primary commissioners of social care. In the past they provided services themselves but these are now largely outsourced. Their main role is to locate and contract with other organisations that provide care. LAs employed on average 1427 employees in children's and adult services and social work, including administrative staff (Eborall & Griffiths, 2008).

These large employers in the sector proved reluctant to engage with the NMDS-SC. They usually declared themselves too busy with what they saw as 'business as usual'. In 2004, at a workshop facilitated by myself in London, co-sponsored by the Employer Organisation and Topps England, over 50 LA representatives were introduced to the concept of workforce data collection and asked to think about the potential to improve how the sector gathered workforce information. The information from this initial direct communication with LAs was to lead to an internal programme of work by the Topss England Workforce Intelligence Committee in October 2004. This included the notion of one single collection

system that brought all England's regions under one wing. It also included an early paper on options for the procurement of such a system (Topss England, 2004).

In 2006, drawing on this initial work, I personally first wrote and then spoke to all 50 LAs who had already engaged with or had shown some interest in the NMDS-SC. From those 50, 35 committed themselves to participating in the LA England Project who were a good range of smaller unitary authorities, traditional larger ones and London boroughs, following a series of meetings and workshops, again facilitated by myself, that provided information introducing the NMDS-SC concept and benefits (including the 'What's in it for Me' documents - Appendix 12). The need to build up support for the NMDS-SC was aggravated by the fact that the social services activities of a LA, although often large, are generally not its key activity. Engagement would often depend on an individual officer's confidence and strategic vision, and whether they thought it a good idea. In response, the process tried to cover all the possibilities. In developing a package of engagement through the workshops, Skills for Care hoped to engage with the issues affecting LAs. This was done within a project management framework. Some of the LAs, who engaged in this process in 2006/7, had been present at the meeting in London in 2004 when they first heard that the NMDS-SC would be introduced.

The full project report of the LA workshops included:

- A checklist of questions each LA needed to consider in advance of participation.

- A managers' briefing. This was undertaken as a presentation provided to the group about the NMDS-SC, what it did, how it did it and what was expected of them.

- The embedded brief Project Initiation Document (PID). This was a fully completed example of the PID, for LA use when developing their own, in their organisation. It included for their use:

    - An example project plan;

    - risk register;

    - issues log;

    - opt in letter;

    - opt out letter.

- Gap analysis format: this contained the full data items for the NMDS-SC to use when considering how to retrieve or create this information in an organisation.

- Proposed changes in guidance: this demonstrated how the standard developed guidance used so far with the interim solution could be modified for use with them.

- Lessons learned – executive summary: providing the brief details of the process jointly undertaken by Skills for Care and the LGA Analysis and Research department.

- Example Reporting from an anonymous organisation 1.

- Example Reporting from an anonymous organisation 2.

The outcomes from the workshops and the guidance given to the LAs enabled Skills for Care to articulate what LAs would get from engagement. High-level backing was obtained from the Directors of Adult Social Services (ADASS) to support the NMDS-SC in 2005, as reported earlier in this chapter.

The Embedding Process

Most LAs located their projects in their HR department, with support from their senior managers. Project planning and risk logs (Appendix 8) were used to varying degrees. Little information was discovered about resource implications. Estimates ranged between £185 and £4334 for undertaking the project in each authority. Other LAs reported being able to find funds for the next phase when they expected to engage with the NMDS-SC.

Data protection issues, as expected, were a major concern for the LAs. Only two chose to submit data without any further action. Some asked staff to opt in; others asked staff to opt out. One submitted data and then informed its staff.

The Children/Adult Social Care Divide

Children's services largely watched from the sidelines, learning what they could from a distance. In October 2007 the Children's Workforce Development Council (CWDC), who had been silent partners in the development of the NMDS-SC, offered funding to support the project. It recognised that the data being produced would be the best available and that it would need to promote it in their sector.

Two LAs participating in this pilot covered the whole workforce, three covered only adult social care, and another covered only children's services. Eight others chose to focus on CSCI-registered establishments to start with. Most picked the least resistant or most willing volunteers in order to get quick wins. Many recognised they had underestimated the task.

Grouping of data was an area where LAs felt they needed further guidance. Five grouped it based on the SSDS001 numbers, an existing system of returns sent back to the DH. Four grouped it into children and adults and two put adults into one group. Only one divided its returns by teams. Another completed it based on the divisional management structure. Most (13) sent out some kind of pre-populated questionnaire, and only one sent the questionnaire to its managers to complete from scratch. Two completed most of the data centrally. One LA used it as the basis of completing its SSDS001 return and reported that this improved the process (through the 'collect once and use many times' principle).

Gathering data was a problem for LAs, as they often found that the data they needed were in different places and had to be merged. This required significant work, as they did not initially grasp what was required. Nine failed to involve their IT providers at all and eight asked for only limited involvement. Four used X system and an IT provider, and four used Y system to provide their systems. Three had in-house systems and the rest used a range of outsourced IT providers (Dunleavy et al., 2011). It was recognised that the process needed to be automated, so it was decided to provide four standard formats that all these providers would be able to choose from.

The project prompted LAs to think about the availability of the data that the NMDS-SC demanded from them. All those who participated had gaps in their data: commonly, information on where staff had been recruited from and where staff went when they left. Most other data items presented a problem to one or more LAs. Although these LAs were undertaking work to prepare for the arrival of the NMDS-SC, the gaps they identified required them to set up systems in-house to collect this new information required by the NMDS-SC.

The paper exercise of these pilots allowed us (Skills for Care) to refine and refine questions and potential ways to respond. It worked well. The data from these was entered by a special data entry specialist company who also supported the technical group to plan the questionnaires beforehand. Remarkable little data was dirty and the completion rate and return were acceptable and in some cases excellent. The documentation worked. With

further refinements the questions and process were ready for the electronic web based system.

As I have stated in Chapter 3, the cost and precarious nature of developing technology systems always kept me on my toes. I was also aware that we had to ensure our focus on supporting system users and quality guidance would be essential if the system was to work to its optimum and of course people were to take it up and complete it.

Skills for Care recognised from the study that all LAs would require specific additional support from the Skills for Care regional staff, and a central point of contact in Skills for Care with responsibility for engaging LAs. In addition to my strategic management of this project, a member of staff at Skills for Care was employed to manage the daily liaison and LA engagement in the NMDS-SC in England. Sample documents and support tools needed to be developed to aid LAs by building on the initial pack used. Marketing materials also needed to be further developed by Skills for Care to promote awareness and engage LAs. A Skills for Care SRI website discussion forum set up to record in detail dialogue and issues was little-used and eventually discontinued, but guidance and a Frequently Asked Questions (FAQs) facility were added. A guide to making returns from non-registered provision needed to be developed that would maximise benchmarking and how these organisations might be compared.

Data protection guidance and assurances needed to be strengthened. It was recognised that LAs would engage faster and more fully if the DH and

Department for Education and Skills (DfES) were to make the completion of the NMDS-SC mandatory.

LAs had data, and some claimed to have a great deal of data that would fit into the NMDS-SC, but it was within their existing systems. IT supplier X needed to develop a system that would allow each LA to download its data automatically. This would best be done through direct engagement with LA IT suppliers. Following a report from the work of the embedding project, four conferences were run, chaired by myself, in the summer of 2007 across England to bolster engagement and awareness. Speakers included representatives of the DH, CWDC and the CSCI, playing key roles on the day as joint owners of the NMDS-SC Staff from over 130 LAs attended these events.

Discussion

A number of possible solutions on how to embark on collecting the NMDS-SC were developed as a result of the pilot studies. It was suggested that data could be successfully collected at the local level via employer partnerships and existing brokerage schemes, as part of the process of funding and supporting workforce training and development.

It was also considered that collecting the NMDS-SC should form part of the CSCI inspection process, although this would only apply to registered providers and would thus collect no data from other providers of social care. The study undertaken in the West of England NCSC offices proved that data was not being collected comprehensively. It was suggested that, as a lever, providers might be

asked to demonstrate to the CSCI, perhaps via a certificate perhaps issued from Skills for Care, that they had completed their NMDS-SC. The mutual interests of Skills for Care and the inspectorate were increasingly made public. In September 2007, for example, a joint statement was issued by Skills for Care and CSCI to demonstrate their commitment to the NMDS-SC following the CSCI revised Annual Quality Assurance Assessment, because inspection requirements issued in April 2007 had overlooked its previous commitment to synchronized data elements agreed between its AQAA and the NMDS-SC (the 'collect once use many times' principle). This was finally achieved in July 2008 when Skills for Care issued the following media release:

National Minimum Data set will make online AQAA returns easier for employers

A new update to the National Minimum Data set-Social Care (NMDS-SC) will make it easier for employers to fill in their Annual Quality Assurance Assessment (AQAA). The new NMDS-SC function means employers can download a single page report which CSCI registered care homes, domiciliary care agencies and nursing agencies can use instead of filling in the workforce section of CSCI's impending revised AQAAs which will be shortly coming into use. The new online report means employers won't have to provide the same information twice and NMDS-SC Online does all the calculations for the employer. The report shows the establishment name, CSCI number, staff numbers and hours worked in the seven days prior to completion. There will be different versions of the report for care homes, domiciliary care agencies and nursing agencies available from www.nmds-sc-online.org.uk. The report is available for downloading to those employers who are already registered with NMDS-SC and unregistered employers can go to the NMDS-SC website to sign up.

This new online report developed with CSCI puts the 'Collect Once - Use Many Times' principle into action and is a huge leap forward in making it easier for employers to fill in their AQAA says Skills for Care CEO Andrea Rowe. "NMDS-SC has always been about combining collecting robust data about our sector easier and providing useful information to employers. This online tool will help employers complete AQAAs by making the sometimes complex calculations automatic."

(Skills for Care, 2008b: p.1)

This demonstrated that the NMDS-SC was becoming more established.

The NMDS-SC early developments and the pilots had begun to show that, if invested in and supported, the NMDS-SC could deliver information on the social

care workforce to an unprecedented extent. The responsibility for supporting the project would not lie with Skills for Care alone, but would need investment and encouragement from all the leading organisations in social care. It would also need good marketing and commitment. The next chapter outlines the development from the hard copy data set into a user-friendly online electronic system for the sector, and also the task of finding a partner to build it.

We needed to understand if the information from the pilots would prove clear enough to demonstrate what worked well in engaging employers and collecting the data required. We needed to begin to understand the practical issues and the most effective solutions to establish this complex development and ensure it would collect what was required from those who held this information in a manner that suited those who would interact with the system.

CHAPTER 7: DEVELOPING THE NMDS-SC FROM AN IDEA TO A SYSTEM

Scope

This chapter will cover the following areas: developing and scoping the idea of the NMDS-SC; providing the interim solution; and procuring the system for development. It was important that the NMDS-SC online system had a clear business case that was supported by stakeholders. A national system to improve the level of information available on the social care workforce was something in which stakeholders had an interest. I understood that achieving this demanded a contribution and a commitment from stakeholders across social care in England. Ultimately if Skills for Care, through my direction and responsibility, built a system that the sector could not, or would not use, it would join the list of failed developments discussed in Chapter 4 (Purao & Desouza, 2011). I worked hard to ensure this did not happen. I needed to learn from the trials and case studies and implement the right changes and developments to the temporary paper version and ultimately the online system.

Introduction

In the previous chapter I described three case studies or developmental steps that helped to build the case for the potential of the NMDS-SC. In this chapter I describe and analyse how the final specifications for the online system were developed. I focus on what became an interim solution before the final electronic product was built from 2006-7. I explain how the interim solution was constructed and the reasons for its development, both as a step towards

the online system but also to avoid the possibility that doing nothing while waiting for the electronic web based system to be developed might have put the whole project at risk.

In addition to developing an interim solution, the time between the pilots and the complete NMDS-SC online system was used for development and marketing. It was necessary to inform employers and advertise what the benefits and uses for the system were, as soon as it was agreed what the online system would do for the sector (Appendix 16). Marketing tools had to be developed and promotion had to take place while a stop gap solution emerged.

Developing the Case for Change

I engaged with my colleagues at an early stage, starting with a series of internal meetings and workshops that culminated in the writing of a business case for collecting better workforce intelligence in social care in England. This needed to be written in plain language so that it would be clear for the sector and forthcoming developers to use and understand. This enabled my organisation to see what was needed, and allowed me to explain the work and try to gain the support of the CEO and the Board (see Chapter 5). It was evident that a clear business case would allow stakeholders to understand the development, as well as making it easy for commercial companies to see what was involved when submitting tenders to build the system. As mentioned in Chapter 4, good project management and application skills were essential for me to understand, use and maintain, given the risk of failure (Kousholt, 2007; De Bakker et al., 2010; Shim et al., 2010).

The first workshops were held in December 2004. Invitations were extended to IT specialists from outside and inside what was then Topss England, and key people involved in data collection: including (internally) the chair of Workforce Intelligence Programme Board, members of the Workforce Intelligence Unit, and senior managers; and externally, the GSCC and the CSCI who had expressed interest in the work.

The initial outcomes from the first session were subsequently written up as a business needs document and used in the 'invitation to tender' process to develop the NMDS-SC online (see Appendix 11).

Risks

There was a concern that interested partners, such as the CSCI, would be subject to organisational change before any product was developed, and that their continued interest in the product's development could not therefore be guaranteed. It was recognised that the funds necessary to render the database functional and national in scope would be significant; the project was likely be expensive. It was thought that a development of this size might need partnerships to fund it and, as a minimum, would need the backing of many organisations.

Assumptions

We knew that there was little data on the sector's workforce, but this would need to be proved as part of the business case.

Specific Steps

We needed to develop definitions of key terms. We needed to fully scope the work and the needs of the sector for workforce information. I understood that determining the range of possible data that might be collected would require detailed work, as discussed in the preceding two chapters.

At an early stage, the question of how information would be gathered often arose. How would we ensure employers provided the data? We needed to determine how data would be accessed after collection. We had to ensure that data was clean and useful, and decide what checks we would put in place to ensure it was valid. We had to decide whether we would aggregate data from organisations as a whole or from the smaller operational units within those organisations. We also had to consider the legal requirements of data protection.

In terms of process, we needed to ask how we would manage the work and whether we would take a phased approach, either regionally or nationally. We had to decide who could have access, and work out who would want access, to the data.

The detail of job roles/work settings, hours of employment, and how these would be collected all needed careful thought. We knew that people working illegally would be difficult to include in our data.

I had gathered from discussions and personal communications that the DH believed that the CSCI could provide the data from their inspection processes

(see Chapter 2), and needed to establish whether this was so. My own view was that this would not be possible.

I had to consider the operational requirements, which included how any system would work and operate. While there was a general aspiration towards achieving better data for the sector in the future, the resources that would be necessary made it a difficult programme of work. I also knew costs needed to be estimated before we could find a possible funder. Some regional initiatives had been discussed previously and they had not succeeded for this reason.

Finally, the detailed work to agree data definitions, for example job titles, described earlier, had always been recognised as a possible stumbling block.

Requirements and Revision

Data definitions had to be spelled out and agreed upon. It was decided that any system needed to work from the perspective of the care setting (the organisation), the local area, and the national perspective. Ideally, it would be possible to drill into the data from a large number of angles, including perhaps criteria such as employee postcode (Ballou & Tayi, 1999; Rob et al., 2007).

I needed to ensure we could be clear about how employers would input data in to the system. We had to be as precise as possible about possible collection methods and recognise the growing power of the internet and its increasing use. The internet was becoming an established tool and it made clear sense to base the system there.

Whatever was decided had to be agreed by the sector. We would need to develop a warehouse or central data store, with the capacity to securely hold a large amount of data.

We needed to build a system that would include data cleansing, removing inaccurate, duplicate and corrupt data. We had to develop a practical approach to owning and building this system.

Early Functional Requirements

These were refined to include the following requirements for the system. It had to be able to:

- collect the NMDS-SC from more than 30,000 different employers;
- provide sufficient collection methods to ensure that all employers were able to provide the data;
- deliver the data to Skills for Care;
- store the data securely;
- provide access to the data at a range of levels;
- provide access to the data for multiple users;
- provide a range of access routes to the data;
- provide access to different parts of the data at different times and to different users;

- allow manipulation of data by multiple users;
- be capable of development in complexity and range in order to meet future demands;
- provide a process for data 'cleansing'.

Developing Operational Requirements

The number of employees in social care varies across providers, as explained in Chapter 2. Whatever system was to be developed, it had to have sufficient flexibility to accept data in different media and formats. The system and processes had to offer secure storage for the data in line with agreed protocols, but also allow access to manipulate the data. It was important that different parts of the data could be accessed separately, so that the data could be used by as many different organisations as possible in order to develop the social care workforce.

The system needed to allow access by multiple users to different data at different times. It needed to be secure against unauthorised access and to ensure that data on identifiable, individual employees could be protected under the relevant data protection legislation and with access limited appropriately.

Options for Collecting Data and Engaging with Partners

A range of options for data collection was considered. Employers had to be made responsible for inputting the data, but the process of collecting the data and delivering it to Skills for Care and into secure storage could have been approached in several ways. At the start it was not always certain that the

system would be technology-based, but, as time and technology progressed, a manual system seemed less feasible and its processing was found to be far more costly than electronic processing. A paper system would not offer the efficiency that a modern technological approach could provide. Design had to be future proof and forward looking. The internet was clearly established and here to stay by 2004. As Chapter 4 discussed, avoiding ICT problems and failures had to remain at the forefront of development.

As noted, some stakeholders were of the view that data could be collected by a third party, such as the CSCI. In this case, data would need to be extracted from inspectors' reports and collected and delivered to Skills for Care. This would involve Skills for Care working in close engagement with the CSCI, and agreements about the extraction and delivery of data. Such agreements would have to be subject to discussion, negotiation and agreement. It would still require Skills for Care to work with another partner in order to provide data storage, retrieval and access. The previous chapter discussed why this option was rejected.

In 2004 there had also been some discussion of whether the organisation could develop or purchase software for a simple database collection, which could then be marketed to the sector. It was thought by some that this would allow the organisation to maintain control of the system. However, this idea raised considerable risks in terms of development and marketing costs. Early on in the development of NMDS-SC, there were suggestions that it might be possible for the organisation to endorse software packages and products that were NMDS-

SC compliant. This would have involved working in partnership with technology companies to develop suitable products to meet the needs of the NMDS-SC project. This would have saved the organisation from having to fund the costs of product development but, in return, the organisation would have had to support the marketing of NMDS-SC compliant products to the sector through its endorsement.

However, this model was never a serious contender, as it was never clear how it could have worked. It was eventually dropped in 2004 after much exploration. I always believed a national system managed by Skills for Care had greater potential benefits for the sector. The issues that were of concern were about consistency, blanket access and use across England. The commitment to funding needed to be agreed to make this a significant and serious attempt by the sector to change what was known about its workforce. Piecemeal agreements with miscellaneous software companies were never likely to deliver this (Face, undated; Risk Manager, 2012). No one has made Local Authorities use the same computer systems; there have always been lots of alternatives and consequently systems vary considerably across Local Authorities. The Integrated Children's System (ICS) is a good example of the problems this can cause. Where the NMDS-SC has been developed with little more than a grumble from those who complete it and much praise, ICS has been perceived as a disaster and has been the cause of much resentment (Weick, 1987; Cleaver et al., 2008; Pithouse, 2010; Ince & Griffiths, 2011).

Benefits

By 2005, everyone working on this project understood that what was to become the NMDS-SC Online would need to provide benefits across the sector. These benefits were primarily directed at the workforce and employers. From those early discussions the benefits of this project were summarised as:

- more accurate data available across the sector;
- streamlining of present data collection;
- enabling improved workforce development and planning;
- improving the understanding of skills needs across the sector;
- better workforce management resulting in improved services.

Once these were agreed, they remained a guide to the process of development and underpinned the first major step of the NMDS-SC as it moved from idea to action. In 2006 Skills for Care compiled a tender for the development of the NMDS-SC online system as a whole, and then entered a legal contract with an IT provider to develop the internet solution: the NMDS-SC online. These benefits were transcribed into a functional system that works well and meets the needs of those who interact with it. KISS (Keep it Simple Stupid) was a mantra during development, which served the project well (Chapman & Ward, 2002). Failings in the ICS system, as discussed earlier, suggest these basic principles were not followed in that development.

Having established the data set and raised expectations in the sector, it was important for Skills for Care to keep the momentum going. A solution was developed, to provide a body of data that could be used once the online system was built.

Constructing the Interim Solution

The data items were turned into plain language questions, and put together in attractive packages, professionally printed, including 'help' documents to aid completion. The aim of this was to help the NMDS-SC become established, providing it with a brand and identity of its own. We needed to develop something that people in social care would recognise. Skills for Care's nine regions were becoming well-known points of contact for social care employers. Each region initially received 1000 packs for employers to complete. A small amount of central Skills for Care funding was provided to support the regions in distributing the packs (around £10,000 each). As might be expected, each region undertook this task at a different pace and in a different style.

Success varied. Some made great headway in contacting employers and gaining completion of the NMDS-SC in hard copy. These regions required more packs after their initial 1000 copies had been distributed. Others were slow and initially made little impact. This appeared largely related to the priority given to the project, by the regional manager and the regional Skills for Care committee. The NMDS-SC was not universally understood or appreciated across Skills for Care. This was an issue I constantly had to address. Managers and regional committees who understood the purpose engaged very quickly, with success. At

least one region had difficulty with its own managerial staff, and the initial 1000 allocated packs were put into storage by a manager who subsequently left the organisation. Those 1000 NMDS-SC interim packs were never found and had to be replaced, and the costs absorbed. Once a new manager was in place, the region caught up, but for several months it recorded no engagement, while other regions exceeded their first targets and had at least 1000 employers entering data into the NMDS-SC hard copy interim solution.

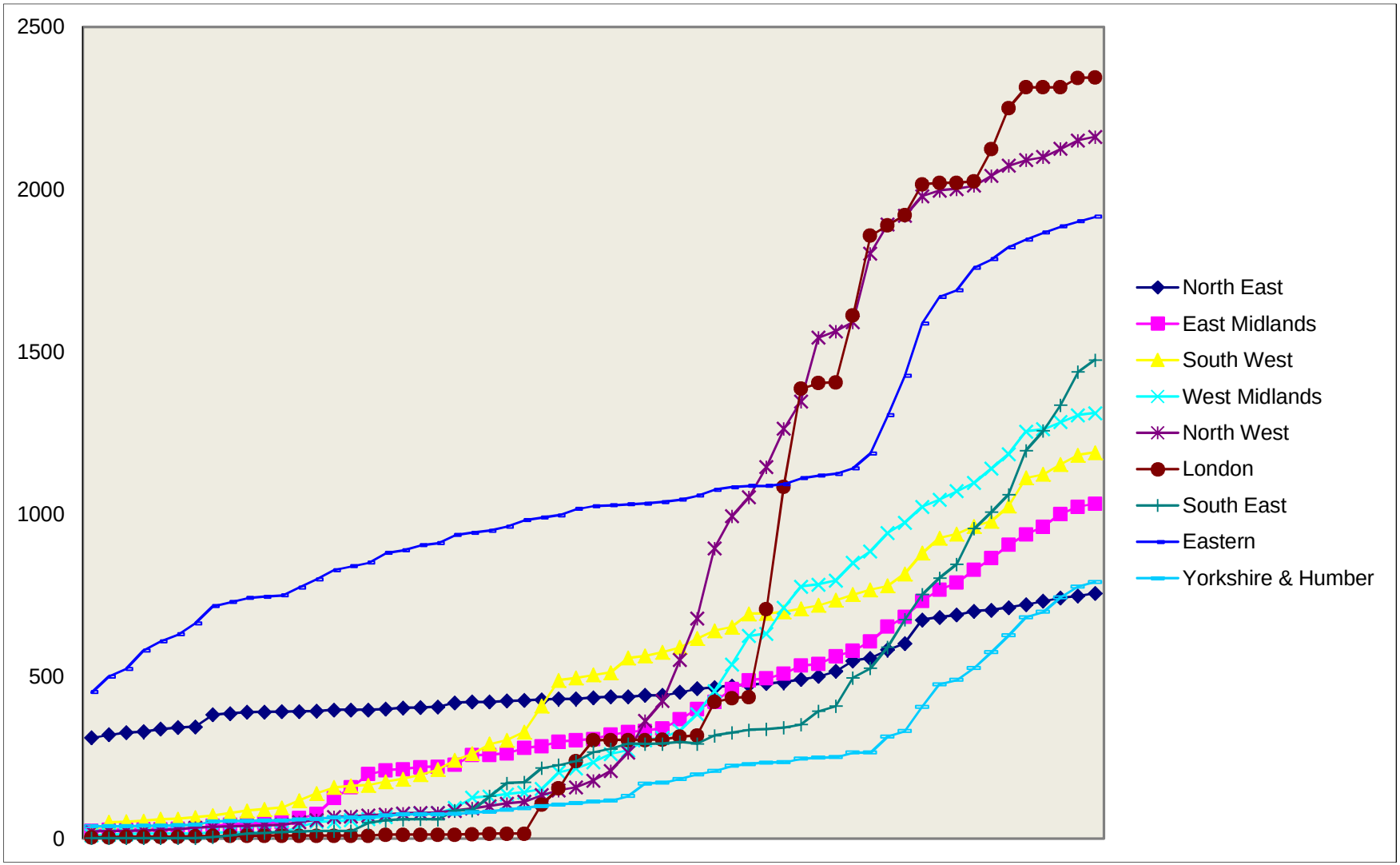
The fact that the NMDS-SC was at first in hard copy and not electronic was fraught with complexity. Some of the programme board had argued that the social care sector was not technically proficient enough to manage IT and that a physical document would be the only way employers would be able to complete it. As noted in Chapter 8, in the early and mid-2000s many employers in social care did not have internet access and IT proficiency was thought to be lower in social care than in other sectors.

As mentioned in Chapter 2, the internet and e-commerce were starting to accelerate as I started this thesis. I had a strong project management background, adopting clear standards and a detailed Project Initiation Document (PID), with Risk Log and Business Case all established. Careful attention to development would enable this to flourish as an online system. I was fully aware that mistakes and any loss of concentration about the importance of the work could jeopardise any future success. Any selected partner development company would have to work to strong and clear project management standards to ensure success. A specialist company had to be

selected. I firmly believed that an electronic system would make completion much simpler as it could be used as a live online facility, in the same way that Ebay, Amazon and online banking solutions had developed. However, feedback from employers at conferences, discussed in the previous chapters, indicated that there would always be some employers who would demand the paper option. We did not know how many this would be, or if the rapid rise of broadband technology across England would make any impact on IT in social care. I was always optimistic that technology would become more common. The online system would be built to iron out the many inconsistencies we had with the paper system. Different people completing a temporary paper solution with support from different interests and perspectives would always be a challenge. The vision was, once online, we would have standardised and universal data fields, agreed support levels and processes for everyone that would be developed from everything we learned from the pilots and the interim documentation in the regions.

From late 2005 and throughout 2006, regions engaged employers, some through outsourcing this task and others through networks in their regions. Initially, the smallest region of Skills for Care (the north east) recruited the largest numbers of employers willing to complete the form. Over 1000 employers completed the form in this region before a single employer in the south east, and only a handful in London, had engaged (see Figure 1 below).

Figure 1: Monthly Regional Paper 'interim' NMDS-SC Returns, June 2006 to August 2007



Skills for Care engaged a widely experienced data entry company to enter the data once the forms had been returned to Skills for Care. This relationship was successful but, as we knew and expected, the exercise was relatively costly, demonstrating that manual data transfer could never be sustained at the level needed to enter data from the number of social care employers expected across England when fully operational. It was simple to transfer the data into the online system when this was fully developed. Many of the employers who completed a paper form had the advantage of being part of the early phased release once the online system was procured and built. This meant they could, if they chose, quickly use the NMDS-SC for their own benefits as an organisation.

Once the interim solution was in place, Skills for Care was able to start data analysis. The first public release of these findings was in mid-2007, with a series of three NMDS-SC briefing documents (Skills for Care, 2007b, c, d).

Promotion and Marketing

As part of the marketing of the NMDS-SC it was essential that the benefits were made clear to those engaging with it. As mentioned in earlier chapters, the development of a DVD that promoted the politics and support of key individuals and their organisations proved successful. The inclusion of logos from the LGA, GSCC and DH to demonstrate support was agreed and included on all interim products. Promoting the product was the impetus for developing the 'What's in it for Me' series documents (see Appendix 12).

These documents were designed to inform different employer groups about why they might have an interest in the NMDS-SC and what it might deliver for

them. These included LAs, smaller and larger employers, Learning and Skills Councils, Skills for Care Regions and Regional Development Agencies.

Regular questions asked about the NMDS-SC were compiled in into a Questions and Answer (Q&A) document. This reduced the need to resource staff to be on hand to answer questions, avoided different employers being given different answers to the same question, and created a uniform response. Once agreed, the answers were available for all Skills for Care staff and others, including the DH, to use.

Discussion

To develop the electronic system that would be the NMDS-SC online, it was imperative that Skills for Care had a clear view of its own requirements. These requirements were developed from 2004 through to the contract signing in 2007. During that period, the interim solution mentioned above was developed and put in place, and the procurement for the system provider was undertaken, including all the reporting specifications (see Appendix 14). The following chapter focuses on the process of choosing the supplier and building the system that would make timely use of technology as the sectors became increasingly familiar with online technology, along with many other sectors of UK society (Leiner et al., 2009).

CHAPTER 8: THE NMDS-SC ONLINE SOLUTION AND FINDINGS

In this chapter, I outline the process of developing and building an online system for the NMDS-SC. I found a lack of detailed published analyses on the subject of successful IT procurement. While there are many examples of the unsuccessful development of IT systems in the public sector (see Chapter 4), for example, National Audit Office (2006) and NHS (2011), there are few accounts of what has worked well and why. This chapter also describes some use of the data illustrating the NMDS-SC's potential for secondary analysis once the number of returns justified this.

Introduction

During the procurement process, a panel was established to select the supplier from more than 60 applicant companies. Though most of them, from their applications, appeared to have the technical abilities to develop the NMSDS-SC, few of them appeared to have the other necessary qualities we were looking for (Miller & Lessard, 2000). We were looking for trust and transparency and a company we would be confident in working with (Dyer & Nobeoka, 2000; Lee, 2009). The process of shortlisting to a final dozen, then six, then three companies, took time and included several days of interviewing. It appeared that some IT companies simply told us what they could do and failed to demonstrate an understanding or clear appreciation of what we, as customers, wanted or how they might work in tandem with us on the developments. Some appeared simply to have the completion of the project in mind and I felt they

would have kept to the contractual relationship of customer and supplier. Skills for Care, through my management, was keen on building a relationship, as a partnership toward a successful outcome (this research had led me to understand the importance of this). We needed to know detailed costs as we had a limited budget. At this point, Skills for Care could easily have made a major mistake and appointed an unsuitable supplier (Gil, 2007). In my view, we avoided that mistake: instead, we found a developer we could trust, who went on to build a system that was designed to a level of detail that was shared with us (Sako, 1991; Smeltzer, 1997). The supplier chosen had a good reputation, completed the work on time and on budget, and at all times sustained our trust (Van Echtelt et al., 2008). We obtained specialist legal support to ensure the contract was clear, functional and ultimately addressed any risks that might have arisen. This was a major IT project for Skills for Care and I felt under pressure to ensure it succeeded.. The contract 'stayed in the drawer' in that we did not need to refer to it further in discussions with the supplier once it was signed (Mayer & Argyres, 2004). Together Skills for Care and the chosen supplier clarified all the requirements for the system and began the process of building it. I still attended all the development workshops, managed the staff working on the project and ensured clarity of communications throughout the whole process. The Online solution, launched incrementally from October 2007, was successful as measured by employer engagement and limited need for adjustment (Poppo & Zenger, 2002). By 2010 thousands of organisations had engaged with it and there have been negligible problems reported about its use.

In April 2008, the bulk upload facility was added. This enabled larger employers with data to submit this efficiently. Advanced reporting tools were developed in mid-2008 to improve information results. Each stage was tested, confirmed and 'signed off' before the next was undertaken.

IT has been dominated by 'waterfall' lifecycle development. This describes the process whereby a project is specified and delivered after some time, then completed; no further changes are made after this point (Royce, 1970). This is when developers are contracted, given requirements and allowed to go off and build it without a dialogue or managed relationship (Sako, 1991; Mayer & Argyres, 2004). No partnership or effective dialogue is undertaken throughout the build. After a period of time the developers return to the buyer and demonstrate what they have built: it is at this point that a disaster can occur (see Chapter 4). This style of IT development favours the developer, who usually reaps the benefits at the end. It has proven to be a major problem in public sector IT systems, as once they are complete, the further changes necessary due to the fluid nature of such projects (where those commissioning fail to determine their requirements fully beforehand and later want something they omitted or simply forgot) usually prove costly to the commissioner.

The development of the NMDS-SC project was completed on time and within its relatively small budget. Partnership with the developer worked well. It took much effort from Skills for Care and the developer made demands that were unfamiliar to Skills for Care. This included the requests to hold development

workshops and the need to abide by a standard of project management that was new and far more demanding than Skills for Care generally encountered.

In June 2008, the Skills for Care Board received an NMDS-SC update document (Skills for Care, 2008c) showing that over 20,000 employers had engaged with the system. This comprised 66 percent of CSCI registered providers of social care. Of those employers engaged, 4,248 employers had completed records for all staff in their establishments. Since the NMDS-SC became fully available, all but two LAs have engaged with the system; over half of engaged LAs had been approved to use the bulk upload tool as at February 2010 (as noted in earlier chapters, in September 2011 the NMDS-SC online became the replacement for the SSD001). Many large organisations in the private or voluntary sector have also used the tool. One example is a company that uploaded records for their 11,500 workers in an approved format, displaying the 'parent/child' organisational structure, whereby central office is able to demand this of its local providers, and managed to complete this work in less than three weeks. At the time we viewed it as essential that the data collected in the system remained clean and functional and we built in processes to facilitate this. The online Bulk Upload Data Items (BUDI), for example, allows data to be uploaded and validated simply by the end user. Where data upload is not successful, because of errors, it fails and an email is sent detailing the errors and what has to be done by the end user to rectify the data and make it compliant to standards (Skills for Care, 2011b).

In July 2008, employers already using the NMDS-SC online system were beginning to realise the benefits of enhanced reporting on their records. They could print out and send, or email inspectors a report containing the information they required, partially meeting their inspection requirements (Kenton, 2005). They could receive a report on their workforce planning needs, to assist them in creating workforce training plans. Large employers and LAs were able to deliver a 'parent' style report to show structural and workforce detail across their organisations.

Reports from the NMDS-SC data set were used for planning purposes in the Department of Health's contribution to the Comprehensive Spending Review of Autumn 2010. LAs started to use NMDS-SC information from organisations in their localities, increasing engagement with private and voluntary sector organisations and asking them through the InLAWS work to share their workforce information. This potentially encourages greater understanding of the geography of a social care workforce and what it delivers (DH, 2007b; Skills for Care, 2009g).

How the NMDS-SC Online System Works

Employers can visit the NMDS-SC website and register. They then enter the details of their workforce, either manually or by uploading a file. They can use this as a tool in their own organisation. Collectively, the data contributes to the overall national figures.

Building the NMDS-SC Online System

The system was developed by the successful bidder following the tendering process. The company made use of the existing reference groups that had been developed by Skills for Care to ensure that what was being built met the needs of the employers, as well as adhering to the initial detailed specifications developed prior to contracting (see Chapter 7).

Some problems occurred along the way, as is to be expected when undertaking work of such complexity. However, the considerable efforts made in planning mitigated the risks of major change to the contract (De Bakker et al., 2010). The project ran largely to plan, the few delays that occurred lasted only a few weeks, and costs were kept within budget.

The amount of telephone support required in order to respond to queries was difficult to gauge in advance. This placed a significant demand on Skills for Care in terms of resources. Although the need for telephone support had been identified, with the benefit of hindsight it was, perhaps, not taken seriously enough, and thus was not planned for sufficiently. The levels of, and balance between, technical and support for social care employers were all agreed in advance of going live. Once the NMDS-SC Online system was operational (Appendix 20) there was increased pressure on Skills for Care to provide a customer support resource. The consequence was that the company provided the technical support and Skills for Care provided user support. Technical support was pure, about such things as failed or forgotten passwords and use of the online system. The organisations that use the NMDS-SC are mainly social

care providers and their interaction with Skills for Care through the NMDS-SC was often for support from another area, such as training or funding. One positive outcome was that those who engaged with the NMDS-SC have since engaged with Skills for Care on other matters, becoming more aware of the support available..

The customer service support desk at Skills for Care was able to differentiate callers' needs and quickly became increasingly important in liaising with employers over workforce issues, as well as technical issues. Perhaps through good project management and development, capacity proved to be less of a problem than in the worst-case scenarios for which we had planned, and the level of support was reduced accordingly. The need to ensure that this was appreciated at high levels in Skills for Care, rather than seen as a smaller 'satellite project' not central to the organisation, manifested itself through significant organisational restructuring. As one would expect, this took time, and it was impossible to measure success immediately. In the meantime, the use of the NMDS-SC continues to grow at the time of writing. As Skills for Care is only one of a number of developmental agencies in the social care sector, with the reduction in social care funding, Skills for Care has been competing against other bodies; SCIE, the GSCC and the newer National Skills Academy - for resources and needs to maintain its distinctiveness. The NMDS-SC has contributed to this as the following sections illustrate.

The Start of NMDS-SC Data

As mentioned above, David Behan once described workforce planning in social care as a desert (Behan, 2008). The NMDS-SC data have improved social care knowledge and possibly performance through providing a greater understanding of its workforce. The system has provided an abundance of previously unavailable information (see Hussein 2009-11).

Skills for Care had always maintained (see NMDS-SC Briefing 1: Skills for Care, 2007b) that improved data about social care providers would allow social care interest groups 'to make rational, objective and evidence based decisions about our sector', no doubt because there was at last a more reliable fund of data available for secondary analysis (as is being undertaken at the Social Care Workforce Research Unit [SCWRU]).

The Skills for Care Briefings continue to be compiled (1-16 from 2007-2011). These briefings were the first attempt to synthesise the information carried in the NMDS-SC and make it accessible.. Briefing 1 stressed the importance of planning for this large sector, as the demands of the future continued to weigh heavily on the social care sector. The first briefing document claimed that excellence in social care depended on developing this workforce. Dame Denise Platt spoke of the "timidity" of the sector (DH, 2007b). A major cause of this had been a lack of evidence about the sector. Briefing Paper 1 spoke of the responsibility that information and knowledge brings in a discursive document. At the time, over 10,000 establishments were engaged (end June 2007), even though the system was then only at a paper based interim stage.

Hussein (2009-11) later began to conduct secondary analysis of the NMDS-SC from the quarterly data emerging. The SCWRU Social Care Workforce Periodical (SCWP) series aims to provide timely and updated information on the social care workforce in England (Hussein, 2009b). Sophisticated statistical techniques over and above those used by Skills for Care are undertaken in order to provide a more detailed look at the research questions used as topics in each issue of SCWP. Sixteen issues of the SCWP have been produced (up to end of 2011), focusing on such subjects as turnover, vacancy rates, workforce profile, pay, younger workers, the adult day care workforce, older care workers, job shifting and the dementia care workforce.

As described in Chapter 2, details of the social care workforce and its services were previously a matter of conjecture. These emerging NMDS-SC data have confirmed that social care provision is complex, with many small and medium sized employers. Its workforce is very different from that of the NHS, in that there are so many different employers in social care.

Skills for Care Briefing Paper 1 estimated that the average domiciliary provider replaces the equivalent of its whole workforce every 3.5 years, and suggested this alone is enough to prevent any real service development. The potential to use the NMDS-SC had been mentioned by a sector representative giving evidence to the House of Lords Committee on immigration (Hansard, 2007), where Lesley Rimmer observed that the NMDS-SC did not cover the migrant workforce. An early addition to the data collected was made in response to policy concerns about migration (Manthorpe, 2009a; Matosevic et al., 2011).

From 2009, the NMDS-SC has asked for the nationality and country of birth of the worker; so future analyses of the data will be better able to estimate the make-up of the social care workforce in this respect. Estimates using NMDS-SC data suggest that 40 percent of London's social care workforce are migrants (Hussein, 2011e).

Analysis from the NMDS-SC Data: The Social Care Workforce

It was little surprise that the first tranche of statistics from the NMDS-SC confirmed that women were the 'backbone' of the service: Briefing 6 showed that 83 percent of the workforce is female and most of those with major experience (more than 20 years) in the sector are women. 60 percent of these women were over 35 years old yet only 64 percent of senior managers were women. Only 9 percent of the men working in the sector have an equivalent amount of experience, and these are usually senior staff, whose experience is different from that of women. This supported the data showing that those with qualifications seem to stay longer in the sector.

Although the issue of gender segregation in the social care workforce had been identified for some time (Balloch et al., 1999), the NMDC-SC offers the potential to analyse the relationship between gender and career progression.

Analysis from the NMDS-SC data: Qualifications

Briefing 4 (Skills for Care, 2007e) focused on qualification data gleaned from the NMDS-SC. The paper opened with a quote from *Options for Excellence*: **'**Our vision is that by 2020 we will have a highly skilled, valued and accountable

workforce. To be excellent the workforce needs to be properly trained and skilled' (DH, 2006a: p.3). Hussein found that professionally qualified workers achieved significantly higher rates of pay. She points out that those in qualified or managerial positions often receive relatively attractive pay conditions compared to others in the sector (Hussein 2010e: p.7).

However, the first Skills for Care Briefing pointed out that the Care Standards Act 2000 enabled inspections to be made against National Minimum Standards. It also stated that by the end of 2005, managers should be registered and possess NVQ Level 4 or equivalent in both management and care; that more than half of the staff should have at least an appropriate NVQ level 2; and that more than half of all domiciliary care should be delivered by NVQ-qualified workers.

The NMDS-SC data showed that registered manager targets were met by 57 percent of managers, though returns from managers were small and varied (Skills for Care, 2007e). The data were far less positive for care workers, averaging only 24.8 percent of NVQ targets across all services. NVQ levels were highest in care homes (at 27.7%) and lowest at 17.1 percent in care homes with nursing (Skills for Care, 2007e). The NMDS-SC data collected, as would be expected, qualifications information, with 'no relevant qualification/non-recorded' being potential returns on qualifications. Since then, the CQC has introduced new essential standards of quality and safety (CQC, 2012).

Analysis from the NMDS-SC data: Pay

Low pay has long been considered a key contributor to social care workforce turnover, albeit with no real data or evidence to support this. The NMDS-SC first analysis reported that only 5 percent of social care workers reported problems with pay as the reason they left their job (to their employer). Nonetheless, the low hourly pay rates of between £5.73 and £6.00 an hour were reported to be factors that affected recruitment and retention (Low Pay Commission, 2009; Hussein, 2011c). The Dilnot Commission in 2011 also raised this issue as part of the challenge of financing long term social care. It has been pointed out that wages account for over 80 percent of the costs of social care (Curtis, 2010).

The third briefing (Skills for Care, 2007d) focused on pay in the sector. As is commonly known, social care workers are not highly paid. The new data showed that the gross median hourly rate for care workers was £5.87, which was only 9 pence more than the minimum wage for people aged over 22 in October 2006 (when the briefing was composed). The briefing revealed that staff with more experience and qualifications in social care received only slightly higher hourly pay rates. It suggested that:

> *An interpretation of this for care workers is clear: to increase your pay, do not take qualifications, with a maximum benefit of 6%, but instead work for an agency and get an immediate increase of 10%. This is clearly not what employers or people who use services want to get the consistency of care they require.*
>
> (Skills for Care, 2007d: p.2)

The briefing proposed that pay structures conspire against the consistency that service users require. Evidence of low pay in social care confirmed the work's low status. It also suggested that that the sector is used as a stepping stone in the job market by many employees, as they move to other areas of work that have higher pay levels and link these to responsibility and qualification (Skills for Care, 2007c).

Further briefings revealed that the voluntary sector had higher rates of pay than the private sector, and, interestingly, a significantly lower staff turnover. The pay difference between care workers and senior care workers was 21% in the voluntary sector and only 4.7% in the private sector: clearly offering a greater incentive to stay longer (Skills for Care, 2007c).

Analysis of this new data from the NMDS-SC identified care homes with nursing as having the best rates of pay for registered managers, possibly as a reflection of the expectation that they will have higher skills needed to manage the residents' care and because nursing homes tend to have larger numbers of residents and staff; yet the basic grade staff in this setting had the lowest rate of pay. Again, a more recent analysis by Hussein of data accumulated in the NMDS-SC suggested that it is likely that 150,000 – 200,000 employees are likely to earn less than the legal minimum wage (Hussein, 2011c). The DH pointed out in response to Hussein's research, that people working in social care express high levels of job satisfaction (DH, 2011a; Jofre, 2011). Low pay in social care is not confined to the UK, but is found in other developed countries like Canada and Australia (Anderson & Hughes, 2009; Palmer & Eveline, 2010). Low pay in

social care furthermore is not as low as in hospitality, cleaning and hairdressing (Low Pay Commission, 2011).

The amount of data has increased since early Skills for Care briefing documents. The secondary research undertaken by the SCWRU details this additional research, confirming the correlation between poor pay and low qualifications in the sector:

> *Workers usually do not expect to be paid very well and while they expect high job satisfaction, they possess few qualifications, expect to work flexibly, locally and often part-time, and may lack bargaining power as [they are] largely non-unionised.*
>
> (Hussein, 2011c: p.8)

Analysis from the NMDS-SC: Job Satisfaction

Skills for Care commissioned a major research study, *The National Survey of Care Workers,* Skills for Care (2007a), which revealed that 88 percent of care workers were either happy or very happy in their work, and 64 percent expected to stay in this work for the next five years. The NMD-SC has identified that this expectation may be an over-estimate and it may be that the National Survey had an unrepresentative group of participants. Social care needs to understand what makes people change jobs. If they are frank in their replies, the NMDS-SC may be able to help employers retain staff longer. The NMDS-SC has the potential to add depth to qualitative studies.

Analysis from the NMDS-SC: Recruitment and Retention

As noted, the loss of staff from the sector is a problem. The briefing observed that 'We lose these staff at our peril' (Skills for Care, 2007b: p.2). Earlier research had suggested that low pay was forcing people to leave social care to earn more money 'stacking shelves' (Cameron et al., 2003). However, the NMDS-SC showed that only 3 percent leave to go into retail work and 18 percent to do another job in social care. Data also showed that only 3 percent of the workforce are recruited from the retail sector.

As discussed throughout this thesis, staff turnover is a significant problem in social care and Briefing 2, using NMDS-SC data (Skills for Care, 2007c), focused on this issue and illustrates the strength of the dataset. Social care in general experiences high turnover, but vacancies remained consistent across the sector: between 3.8 percent in the adult care sector as a whole, up to a national figure of 5.9 percent in domiciliary care. These figures relate to a workforce that is largely (95%) permanent, so are not the result of temporary employment. CSCI-registered establishments had a higher turnover rate than non-registered ones at 13.3-19.7 percent. They also carried a slightly higher vacancy rate at 4.0-4.5 percent. This briefing pointed out that the high cost of training and the loss of staff from the sector when they leave equated to an estimated £78m a year (based on an estimated workforce of 1.2m). In addition to lost investment in training, replacement costs have to be absorbed, and these costs can be considerable. It is estimated that all local authorities spent £15.7m during that six-month of 2005, £3.4m less than the £19m over the corresponding period in

2004 and a significantly reduced estimate of £5.5 million on adults' social care recruitment advertising over the period 1st April – 30th September 2006. This was a significant fall from 2005 (Local Government Association, 2007).

More recent research, based on much larger data from the NMDS-SC, suggests that turnover has, if anything, increased. The care worker turnover rate stands between 22 to 23 percent. This is higher than the average for other work sectors in the UK (15.7%) but considerably lower than the 34 percent turnover rate found in the catering and leisure industry (Hussein & Manthorpe, 2011).

Skills for Care briefings also showed that the lower the grade of staff, the higher the turnover. Vacancy rates for care workers were more than double those of registered managers, at 24.5 percent versus 12.1 percent. The data revealed that domiciliary care had the highest rates of both staff turnover, at 24.9 percent, and vacancy rates at 5.9 percent. This high rate of turnover means that in less than four years, a typical domiciliary care establishment with 30 staff has to recruit at least 30 times to fill posts vacated (Skills for Care, 2007c).

Briefing Paper 2 asked what makes people leave, and commented on how social care may be able to improve staff retention. It suggested that improved relationships between employees and service users, and good relationships within organisations, were the key to customer satisfaction.

The NMDS-SC data at the time of this Skills for Care Briefing showed that 47 percent of registered managers possessed NVQ level 4 and a further 30 percent were working toward this, with an additional 6 percent working towards other

relevant qualifications, under the DH targets existing at the time. The picture was different for domiciliary care workers, where those with NVQ level 2 stood at just over 19 percent. Even with those working towards qualifications, the turnover figure of 28 percent for domiciliary care makes establishing a qualified workforce rather a remote possibility. The briefing paper suggested that staff turnover is a problem that stops the sector from reaping the benefits of significant investments (Skills for Care, 2007e).

The new NMDS-SC data have been able to demonstrate other new findings about qualification levels among the sector:

(i) Age: Those in the 35-44 age group are the most likely to be qualified, followed by the 45-54 years group (both showing at least 38% qualified at Level 2 or above). The age groups most likely to be working towards qualifications are the 18-24 and 25-34 groups (both with 20% or more working towards relevant qualifications).

(ii) Investors in People (IiP) Status: Workers within IiP recognised establishments are both more likely to hold or be working towards relevant qualifications.

(iii) Full time and Part time: Full time workers are more qualified and more likely to be working towards qualifications at Levels 3 and 4. Differences at Level 2 are less pronounced, suggesting that training opportunities at this level are available to all.

> (iv) Length of Service: It would appear that the target of getting new staff inducted and into training within six months has had some effect, as there is an increase in care workers progressing to a qualification after one year in service. The percentage both holding and working towards qualifications at Level 4 and above increases consistently with length of service, showing that some staff are involved in training throughout their career.
>
> (Skills for Care, 2007e: p.3)

More recent studies by Walsh et al. (2011) and Van Walraven et al. (2010) have supported the importance of continuity of care for people using services and their carers.

The issue of the continuity of care, and how a lack of continuity can contribute to service users receiving low quality services, have also been considered (Skills for Care, 2008e). NMDS-SC data permits some analysis of what seems to affect employee length of service in the sector as a whole and the length of time in their current job roles. It has emerged that:

- Unqualified staff are less likely to remain in a job.
- Qualified staff are more likely to remain in a job and in turn go on more often to become senior staff.

- Domiciliary care has the greatest problems with staff retention - proportionally home care staff are less likely to remain in the same job for more than five years than others.
- Women stay longer in social care work.
- Small employers seem better at keeping their staff and have more employees who have stayed in the same post for longer.
- Half the people who start in the sector are in different job roles within two years and working full or part time appears to make little difference.

Although the NMDS-SC had fewer returns from large employers at the time of Skills for Care Briefing 2, it did appear that smaller employers who have a 'family' style approach to managing their workforce may have better retention. Perhaps once organisations reach a certain size and the 'family business' becomes submerged to corporate management, employees become less happy in their work and then leave? While social care work may be low paid, a job that has flexibility and an employer who understands staff needs, and supports them to meet other responsibilities while still providing work that is fulfilling, may be attractive.

Another conundrum emerging from the NMDS –SC data is that those who have working remained in the sector longest are also those with the greatest number and level of qualifications. If staff become qualified, do they stay committed to social care; or is it just that they are not willing to move (Skills for Care, 2008e)? Analysis of NMDS-SC data demonstrates that care staff move around the sector

and are not inevitably lost to social care. The details show, for the first time, that:

- of those who joined the sector between 2000 and 2002, 53 percent are in the same role;
- of those who joined the sector between 1995 and 1999, 41 percent are in the same role; and
- of those who joined the sector between 1990 and 1994, 30 percent are in the same role.

In turn, the National Survey of Care Workers showed that 43 percent of those responding felt they had the possibility of promotion or career progression within two years, but the majority said they were not actively seeking this. We know that higher grade staff remain in the sector longer, so there may be a case for improving continuing professional development and training.

Direct Payments and Personal Assistants

Naturally the NMDS-SC cannot provide all the information that is needed and the example of personal budgets suggests how other forms of information may be needed. The Department of Health's paper *Putting People First* (DH, 2007b) stated that personal budgets should lead to more staff staying in the sector. It said it would require a review of how career progression, supervision and staff training and support were to be offered in these situations. Skills for Care published some early research on direct payment recipients, exploring their employment roles (Skills for Care, 2008a). It commissioned this study to gain a

better understanding of the needs of direct payment employers and personal assistants (PAs). This research was intended to improve the abilities of Skills for Care and others in social care to support the training and development needs of direct payment employers and their PAs, based on qualitative data rather than anecdotes. Further research from Arksey and Baxter (2011) and Moran (2010) supports the need to undertake more work on this subject.

Conclusion

The NMDS-SC Online worked well in terms of coverage and completion. It has changed the availability and quality of social care workforce data, as this chapter has illustrated. The online system now supplies the best available information on this workforce (Eborall et al., 2010). The next chapter explores the impact of the NMDS-SC and some of the potential uses of these data for social care planning, now that this information and system are established. I discuss the development of a team to deliver the system and the use of experts from outside social care. The potential for using the data and the flexibility built in to the system to ensure it is durable are also covered. This final chapter brings together the findings and the discussion of this thesis.

CHAPTER 9: LIMITS OF THIS STUDY, CONCLUSION, AND RECOMMENDATIONS FOR THE FUTURE

Reflection on Methods

This thesis developed as result of my efforts to develop an information system in my work as a senior manager (Head of Skills, Research and Intelligence - up to May 2008) at Skills for Care, the Sector Skills Council for England, and to produce research to support my arguments. To some extent these two activities grew in parallel. As is standard practice in research (e.g. Greenhalgh et al., 2004), but less common within projects undertaken in work settings, I undertook an initial literature search to see what had been written on the subject. I have reported earlier on the frustrations of finding very limited data when I first started the thesis, and set this in the context both of the aspects of social care that made it important to collect better data, and the circumstances of this disparate sector that made collection difficult.

This thesis has charted major developments in social care workforce data collection across the last decade and identified new research possibilities. I chose to demonstrate these developments though case studies and the NMDS-SC innovation.

As explained, there have been significant changes in the availability of information about the social care workforce in England, and the construction of the thesis has prompted further reflection on the use and purpose of obtaining such information. This has been informed by the use of reflection (see Chapter 4) developed by Borton (1970) in thinking about social work, and adapted by

others, such as Rolfe et al. (2001) and Fook (2002). They seek to identify the 'what', 'so what' and 'what now' processes. On looking back at this thesis, adopting a reflective stance has helped me understand the interrelations between these questions.

The hardest part has been keeping my eyes firmly on the bigger picture of the NMDS-SC while attending to the minutiae, including supervision and management of the team. I am sure that having embarked on this thesis enabled me to reflect on and understand 'the what' in a way that enabled me to record matters and events in a more considered way than I might otherwise have done. Early on I chose to keep a strict record of chronological debates and events to improve my understanding, aid reflection and document the process accurately. My timeline (Appendix 3) was developed from my far more extensive log of events. This enabled good reflection as I built upon my initial map of the social care sector to develop the solution to improving what we know about its workforce.

Reflections on Self and Research: Insider Knowledge, Bias, and Limits of the Work

Working for Skills for Care, with a responsibility to improve workforce information, I was ideally placed to make changes in the sector and manage the process (Cameron & Green, 2009). I am an action orientated innovator on the Myers Briggs Type Indicator™ scale as summarised by Cameron & Green (2009) and Reinhold (2011). I like to generate ideas and am committed to achieving outcomes that produce meaningful and measurable results. However, the

position of ‘insider researcher’ carries its own risks as well as advantages. These depend on others’ perception of you, your own position to affect change, and your own ability to champion change (Hewitt-Taylor, 2002; Brannick & Coghlan, 2007; Mercer, 2007). The latter relate to the unique access to discussion and negotiation to which, had I been an outsider, I could not have been privy (Bridges, 2001). It was important, in undertaking this thesis, that I was aware of my position and the risks of any bias it might give me in reporting how I made decisions and developed solutions for collecting information on social care.

There is no doubt that my position as a Skills for Care senior manager gave me access to government and sector policymakers to an extent that I would never have been able to gain from an independent position on the outside. I recognised that I worked for ‘the company’ and would be expected to ‘toe its line’. My own confidence and experiences, and my belief as to how and what kind of a solution was required, were sometimes at odds with my colleagues, and this made my life uncomfortable at times. I have tried to reflect the inevitable subjectivity of the way these events are charted in this thesis, such as tensions with managers and the Board.

Could I remain objective while deep in case studies and strategy development? I would argue, as others have done (Dwyer & Buckle, 2009), that the position of being truly objective or entirely subjective is more an ‘ideal type’ than a realistic possibility. I was able to help the organisation make change partly because the process of undertaking this thesis allowed me to establish a more objective and

questioning perspective, and to maintain that perspective whilst conducting the work. I read widely than I ever would have done had I not embarked on the thesis. Indeed, my academic *persona* enabled me to play devil's advocate on numerous occasions and gave me far more insight into others' working perspectives than I would otherwise have had, such as the perceived impact of the development of the data set itself on the work of managers of small care homes.

As Fetterman (1989) observed, people in situations such as mine need to recognise their position and at the same time understand the role of the research in the complexity of policy and service change. My intentions were 'biased' from the start, in the sense that I wanted to find an enduring way to improve what social care knows about its workforce. My position was also 'biased' in that as a senior manager I had access to senior civil servants, as described above. I had worked in the sector for many years, and I knew it well. Unlike people from a predominantly Local Authority background, I had many years' experience of working with private sector employers as well as policy makers. This longevity gave me distinct advantages, as Hockey (1993) suggests, because I was able quickly to appreciate the complexity of the task at hand. I also worked for an organisation that was at some small distance from government and employers, but had clear encouragement from funding bodies, such as the DH, to improve the poor state of information on social care. At the same time I combined my work objectives with my research objectives, to take advantage of a unique opportunity to decide what the best solution would be

and to challenge all the 'insider' organisations to resource the work. In my view, if they really wanted to achieve change then they needed to invest. Investment was always a challenge and never a welcome subject to raise, particularly as the NMDS-SC necessitated major financial underpinning and possibly an equally challenging investment of time and interest from all in Skills for Care, ranging from the support staff to the Chief Executive Officer and directors, right through to the Board.

I did not 'wear a notice' telling people about my PhD research, but it was not a secret either. Clearly, my own manager had to be informed. Over time, almost all of my colleagues and many key figures in the sector were informed either directly by me or by others that I was undertaking a PhD. At no point was I aware that it closed doors for me, as Shah (2004) suggested might be the case, though this of course is a subjective view. I think, on reflection, that it rather gave my position more strength: people recognised that I was on a mission to research the best way to find a solution, and not simply one that suited my organisation or seemed to be the most achievable. Social care strategic planning is a small world and most people knew of me and my work. I think also those who actually knew me were aware that I was not scared of the challenge of developing the NMDS-SC and charting its development in a theoretical and research-based framework. People worked and spoke with me because in most cases they knew me or were influenced by who they thought I was (Drever, 1995), or because they understood my desire to achieve change. I recognised the separation between the two events and that the PhD would not be judged

on the success or failure of achieving change in the sector. After all, the sector had managed to establish an acceptance of a level of mediocrity in information about itself and my academic position supported me in challenging this.

I was doing nothing new. Many students complete courses whilst working part time, continuing their jobs, although, as Mercer (2007) points out, the literature in this area is not as extensive as one might expect. My position differed from the one Mercer described in that my work remained full time and my research became centrally entwined with my work. This was deliberate: I sought support for my PhD proposal as soon as I recognised the unique opportunity available to me. Fortunately, my manager was always keen for me to develop the research. I would like to think that she enabled me to challenge the sector by supporting my academic intentions, believing I would be better equipped to inspire the organisation and disturb the *status quo* in social care's strategic thinking.

Morse (1998) strongly advises potential students not to undertake research where they work because it can place one under 'untenable pressure'. This never occurred with me. Had I not been on the inside and been familiar with the players and the terrain, I should never have achieved such success in gaining 'buy-in' on the development of the NMDS-SC. As Platzer and James state:

> *'Insider' status can reduce many of the problems associated with conducting sensitive research in terms of access, rapport with subjects, ethical concerns and stigma cognition, but by the same token they lay researchers open to the charge of bias thought to be inherent in 'going native' or rather in the case of being native.*
>
> (Platzer & James, 1997: p.626)

It is the start of an improved information flow that provides the middle part of this reflective process, considering the changes that have occurred already. At the time of writing this section (2011), the moment for the 'what now' question has come. Will this new information and clearer picture of the current position of this workforce have any long-term impact? Will things be done differently in the future because of this data? The work of InLAWS (Integrated Local Area Workforce Strategy) has been mentioned in Chapter 2, and addresses this very question, supporting LAs to support and develop services in their locality using good information on the available services, workforce and need. It is developing at a time of reduction in public sector finances, amid the constraints of increased demand caused by demographic changes and an increase in the prevalence of disability (Moriarty, 2010; Ward, 2010).

Limits of the Study

In writing this thesis I have consciously limited certain aspects of my research and the development of the NMDS-SC. The work has been written over several years while I was working full time. I have had to make a stern effort to conclude the research and draw a line under this study. I have not gone into detail about such aspects as procurement, as this process was not particularly new. New NMDS-SC research findings are now occurring frequently and have proven hard to cover comprehensively, and there is now substantial secondary analysis being undertaken at the Social Care Workforce Research Unit, King's College London.

Rigour and Robustness

The second case study in Chapter 6, on data collected by the regulator, highlighted the poor potential for collecting workforce data from what I then thought to be the best possible source. The views of organisations and key people in social care were solicited throughout and many of these played a key part in developing changes through their varied roles in committees and boards driving the work.

Sustaining an Idea and Achieving Maximum Impact

Having developed the NMDS-SC Online, it was essential that it achieved its maximum potential. This project provided the opportunity to elicit all this information from employers about the workforce in one place for the first time. It is now important to ensure the analysis of the information is the best it can be, and that the data are maximised to inform the micro and the macro developments of social care in the future. This is something that I and many in the sector were initially uncertain about. I knew it would be a challenge to encourage some small employers to use the system to its potential. Further work needs to be undertaken, in a creative manner, which will flag up the potential benefits of having this new information (see, for example, the work of Hussein, 2009b).

I do not believe that all the potential ways of using NMDS-SC information have yet been recognised. We now have more detailed and better quality data than the sector has ever known about its workforce. Time will tell if this data enables the sector to use its resources more appropriately. For example, will this lead

employers to manage their staff in a way to ensure more accurate deployment and better use? Social care is under pressure at a time of economic downturn, and needs, more than ever, to improve the focus and efficiency of investments in the sector. LAs and partnerships need to commission the best and most appropriate services for their population, and to ensure that only the best services and the best employers receive investment. Perhaps the notion of a 'quality employer' will come to the fore and may prove to be a benchmark when commissioning. These employers are the ones who support and manage their staff and often have the least staff turnover.

It is essential to ensure that resources are used to their best effect. Commissioners need to be aware of the local characteristics of their workforce. Communities could 'own' their own services, because they are the experts on what they need and what is delivered, as *Putting People First* (DH, 2007b) advocated. The work of InLAWS started to challenge this commissioning practice, turning the clock back to local control and neighbourhoods as understood in community work practice of the 1970s and early 1980s (Freire, 1972; Hendeson & Thomas, 1980) and much lauded by the Conservatives in what is now being described as 'Big Society' (Bunting, 2010).

The social care sector needs to undertake forward modeling and serious 'what if' thinking. This might re-position the world of social care staff, as the shape and nature of social care provision in the future will be more firmly based on cost. Political decisions are influenced by multiple factors that can include scandals, public anger, cost and their own political values. Politicians will decide

how we as a society provide social care for the future, even if their decisions are informed by research and recommendations such as that undertaken by the Long-Term Care Commission (Dilnot Commission, 2011). Politicians will decide the balance between what policies it will fund through taxation (Churchill, 2011) and what will be left to the market. The work of Hussein (2011e) on how services are being sustained by new migrant workers is significant here as their use rests on political decisions about free labour markets and immigration policies. Politicians know that social care is likely to be under pressure in the next few decades with demographic changes and the rising costs of life time illnesses (Einfeld et al., 2010). There may be policy encouragement to increase the size of the workforce and ensure the safety and well-being of those needing care but this is not an exact science. I believe the information from the NMDS-SC can play a central role in deliberations over future models of care.

Social care and its successes (or its failures) are governed largely by a determination either to engage in the issues or simply be pushed and pulled by conflicting demands. My experience with LAs in the development of the NMDS-SC has been difficult, as unsurprisingly these employers do not co-operate as one single body. LA employers are diverse and each experiences different issues according to their context, political governance and other factors (Presthus, 2010). Efforts were made to enlist and gain the support of LAs (for example, as stakeholders in the work described in Chapter 5) and yet, as late as November 2009, less than half the LAs in England had engaged fully in NMDS-SC Online. It took almost six years (2005-2011) for the DH to require that LA complete the

NMDS-SC as their official annual return, replacing the SSD001 returns. I first approached them through the Employers Organisation 2005, in partnership with TOPSS/Skills for Care, making great efforts to gain their attention, to prepare them and seek their support for the project's development. Sadly, initially this was not as successful as it might have been, but the downturn in the economy has helped focus LAs' attention by forcing them to re-consider their use of resources. Had the DH decided to insist upon completion of the NMDS-SC by LAs earlier, they may have become fully engaged sooner. However, the DH too needs to tread a careful path in its relations with local government. Some employers will always say they are too busy and have no time to be pro-active or engage with change. On reflection I should have made far more effort to engage those LAs who were enthusiastic from the start, using their influence to encourage those who chose to ignore the project.

Background to the Findings

The relationship between those who gained high star ratings quality ratings from the regulators and those who are engaged with the NMDS-SC is worth highlighting. Such ratings affect bed occupancy or commissioning and have encouraged social care employers to become more commercially minded in how they operate in the area of regulation (Matosevic et al., 2011). Small, medium and large businesses in all sectors are controlled by their viability and efficiency. The closure of the company Southern Cross, which held 9 percent of care home provision in England, caused a wave of concern across the social care sector and more widely, with fears that it could happen again (BBC Online,

2011). Where providers fail to keep up with consumer trends and to modernise, they may decline. Where management is poor or shareholder profits dominate their objectives, they may cease trading and cause shortages of provision or disruption in the sector.

Future Research: Recommendations and Implications of this Research

This research has charted the development of an innovation, the NMDS-SC online. I have discussed my role as a working manager, taking forward this project while undertaking 'action research'. I have considered the difficulties of engaging stakeholders and, indeed, examined who are the stakeholders in this sector. I have shown how difficult it was to research this area and acquire qualitative data on 'soft activities'. I have reported and discussed the significance of meetings, communications, conferences and events where contributions were sought and ideas discussed. The problem of the size, variety and difference of this disparate sector was always and will remain a challenge, especially in a climate of government being opposed to what it deems to be unnecessary regulation of the sector (HM Government, 2010). However, recent moves to centralise government apparatus may not signify a reduction in regulation; they may instead simply indicate changes in the methods of regulation (Bönker et al., 2010; BIS, 2011; Hanssen & Helgesen, 2011; Kröger, 2011).

Scarce and poor data have always been a problem in social care and I was trying to challenge both of these. I had to work in an environment that was rarely inclined to research itself and its operation. Social care and the people who

work within it and affect policy and change are varied and spread among many organisations.

The position of some LAs in failing to see the benefits of the NMDS-SC is not a problem exclusive to the public sector. The analysis above is mirrored across all social care employers. I suspect that an analysis of those employers who engaged early with the NMDS-SC would throw up a strong correlation with those who are both good employers and good providers. The converse might show that those who are slow to modernise are the employers that struggle to maintain standards and rarely originate developments. In my view, these will be the last to enter the NMDS-SC and the last to benefit from what it can do for them. Social care providers are numerous and diverse. Social care is not a rational system and those who provide services are often in direct competition with each other (see earlier chapters discussing complexity and change management). Sadly, I believe these are the very employers who need the NMDS-SC the most. This correlation needs to be proven. The characteristics of good employers could then be used to improve the poorer ones, forcing them to improve their commissioning, their management, and ultimately their spending of public money (through its various subsidy routes) to provide better social care.

I have outlined the complex history of social care. Research contributes to social care's history and this work is no different. Social care information has changed dramatically since the arrival of the NMDS-SC (Eborall et al., 2010). Major national IT developments of this type are a new phenomenon in the sector

(Chapter 4). If the development of the NMDS-SC had been a failure or a poor experience then its memory would linger and future opportunities to make such an impact right across the sector might not have emerged for some time.

When looking at the development of this major IT project I had to understand the history of such work, and theories of its success or failure. Over and above that, I had to work in a sector where IT solutions were not commonplace and experience of IT was sometimes minimal. Across social care people were very wary of large IT developments and many told me they had no place in the sector and would fail in social care. I believe that small and local perspectives are very important in social care innovation; but I also believe that technology can support the development of good quality social care. I also recognised that resource issues would always be the biggest influencing factor in the availability of good quality social care. The NMDS-SC revealed a picture of social care that had previously been only guessed. The science of good quality statistics in large data sets (Hussein, 2011a-f; Moriarty et al., 2011), brought about by robust research and development, may now influence the future in a way never previously possible. It will always be vital to remember the importance of data quality and maintain return rates, as discussed earlier.

When analysing the NMDS-SC in the future it is important to be aware of the following:

- There is a lack of a sampling frame: all social care providers are invited to complete the NMDS-SC, but only recently has there been any

obligation to do so. Previous completion has been based on incentives around training support and workforce reports. Some providers will and do choose not to complete the NMDS-SC, yet the completion of NMDS-SC has continued to increase over time. The NMDS-SC is gaining national statistics status in 2012, which will encourage more employers to complete it. We have no complete list of providers of social care in England to check the coverage, except for the CQC list, and individual employers (through personal budgets, for example) are not covered along with some small private and community providers.

- It is important to recognise that the NMDS-SC is cumulative in nature when considering any trend analysis. Returns do not follow a sequence and are not regular. Returns depend on the different providers' willingness to go online and complete and on the frequency of systems updates. This is something to consider with any trends and longitudinal analysis. All data are completed by employers about employees, so it is important to be aware of accuracy, especially in relation to sensitive data, such as disability, ethnicity and nationality. Pay data are provided by employers and are not checked through official HMRC returns and this needs considering in relation to their accuracy and it is not be clear if hourly rates of pay are 'enhanced' rates or the usual rate.

Recommendations for Policy

Social care is a large and important sector of the economy. It will arguably increase in importance and profile with the growing older population. All

parties acknowledged this in the 2010 election (Pool, 2009) and, at the time of writing (2011) a clear solution to funding appears some way off, although a White Paper is scheduled for 2012.

The GSCC's limited impact on the social care workforce, and its closure in summer 2012, also changes the sector. Its regulatory role is being replaced by the Health Professions Council. As yet, the majority of social care workers have no umbrella of professionalism or professional identity. The NMDS-SC does not and will not alone do anything to improve and assure quality in social care. What it will do is provide evidence of stability or turnover in the workforce and details of important trends across the sector. Social care regulators may use such information to focus attention on standards and consistency. A recognised and visible, stable and consistent workforce that showed improved up take of training would greatly assist this challenge to provide good social care.

Recommendations for the Provider Sector

Social care is nothing without those who provide the services; the thousands of residential homes, day care and domiciliary care providers, respite facilities, their workers, care managers and social workers in community based settings, and growing number of personal assistants who together make up the social care sector. The complication is that these people and organisations are not homogenous in any obvious way. As discussed above, because I was working in social care at a national level, I believe this gave me an advantage in appreciating the diversity and interests of this disparate group.

I spotted the links between funding available to the sector through Training Support Initiative money and suspected that this was a lever that might entice employers to join the NMDS-SC. I also recognised the potential links between regulators and providers. In my experience, providers seek to please regulators or inspectors but, if possible, to have as little interaction with them as possible. They know problems raise their profile in a negative way and give them a poor reputation with inspectors. I encouraged inspectors to engage in the development of better information that would ultimately improve their own knowledge, I suspected that providers would engage and co-operate with the NMDS-SC if they thought it would improve communication with the regulator

Social care is a mixture of the traditionalist, the creative and the opportunist. Local Authorities have always been the guardians of the public purse and some still undertake (albeit in a lesser role) the provision of social care services (though they are more frequently mainly the funders of social care through brokerage and contracting). The private sector, by its very nature, needs to be commercially minded if it is to stay in business (Matosevic et al., 2008). Nonetheless, the perspectives of those providing social care at the front-line of care home management, for example, are complex (Le Grand, 2003) and developing trust and demonstrating the genuine benefits to be gained were challenges throughout (Jackson & Parry, 2007/2011; Thomas et al., 2009; Armstrong, 2009).

Flexibility for the Future

One of the clear characteristics for the NMDS-SC was that it had to incorporate an ability to change over time. We could not create a system that would be redundant in only a matter of years. The NMDS-SC was designed and built to be sensitive to the future and to be simple enough to change over time as the needs of the sector for information changed. It also needed to be managed so that change was kept to a minimum, in order to create a source of good longitudinal information. Evolution is essential and in developing the NMDS-SC it was an important feature. This meant that as new ideas emerged over time (such as the recent interest in the migrant workforce) the flexibility of the system allowed for changes to be considered and, if appropriate, new data included through planned change (such as asking questions about citizenship).

Marketing and the Size of the Task

I recognised that the NMDS-SC was a major development and that it would take a great deal of persuasion to get the sector to adopt it. On reflection I never appreciated how big a task it was. I could have perhaps focused even harder on the senior staff and directors within the sector, selling it to them and helping them understand it earlier than they did (Venkataraman, 2002). I knew that even the best marketing of the NMDS-SC Online, demonstrating all the benefits, would not engage all employers. Promoting the development had to be undertaken on two clear levels.

This started at a national strategic level with organisations like my own employer, Skills for Care, the DH, GSCC and the NHS, as described in Chapter 2.

Gaining formal links with the NHS data developments proved difficult and I could do little more than build some data field recognition into the NMDS-SC to be activated later if needed. It also had to be implemented at local and ground level, with smaller providers, such as the bus project mentioned in Chapter 6.

Employers who saw something in the NMDS-SC Online that they liked were stronger promoters and better than any marketing tool. They were happy because they recognised that the time spent in entering data was well used, as they then met the needs of the regulator and also met the needs of the many funding streams they needed to access. These employers influenced their peers.

Ideas and Skills from Outside the Social Care Sector

I have always tried to make a difference in any work I have undertaken, both personally and professionally. I strive for continual improvement and have always tried to develop ingenious and efficient ways to complete any task. I think of myself as a good organiser and a project manager. I had worked in social care for decades and knew of no-one who had developed IT knowledge about the workforce. I was aware of the context of the public sector as discussed earlier. I was also aware of successful commercial developments like Ebay and Amazon and could see that their wide use by members of the public might suggest growing familiarity and confidence with IT.

As mentioned in Chapter 7, I personally knew someone in the world of banking IT who had been part of that world for more than 40 years, and had extensive experience with national and international projects. He was able to advise me.

The dominant advice he gave me in the early days of working with this idea was to make sure I knew exactly what I wanted before we engaged any IT company for development. He told me to make sure I could describe, in non-technical terms, exactly what we wanted any system to do. This advice was significant and meant that a great deal of preparatory time was spent developing and agreeing what the NMDS-SC system would do. Then, and only then, did we enter the world of IT procurement. I understood that where I had any 'holes' in my vision, then IT providers could help. I understood that this is usually what both delays any development and escalates any initial costs.

Skills for Care was full of excellent people from the sector but they had little experience in finding the right people to undertake large IT contracts. It had its own in-house IT department but its staff did not have the background or experience needed for the project I envisaged. I was clear that Skills for Care needed to gain IT procurement support. I found this through consultancy. We had to make sure that when we made our selection we had our own advocate who spoke the language of IT. We did this with a company specialising in IT procurement. I helped procure and select the eventual successful provider that possessed substantial technical knowledge and sector insight. We ensured that the successful company chosen in the procurement process could deliver this work incrementally. We also needed to pay incrementally on time and on budget, which was achieved.

Trust

Trust has to be developed because a relationship built on this often works much better (Smeltzer, 1997). When procuring a builder for this system I recognised the need for a partner I could trust (Gullet et al., 2009; Urbano & Oliveira, 2009). The project required a company that could understand Skills for Care and social care, and whose staff could be trusted to build it in the spirit of scarce resources in social care. I placed heavy emphasis on selection of this supplier at the time. The supplier chosen worked hard to understand the nature of the social care sector. Overall it has been a good partnership in my view.

Legal Guidance and 'Expert' Lay Input

In some instances I have made use of some friends and contacts that I have considered to have knowledge or expertise that would benefit this thesis. Upon reflection, I did not want to be remembered as a person who wasted public money (see, for example, Denny, 2003) and achieved no benefit. I always recognised that these developments would require good legal advice and that the legal work around contracts and partnership in the creation of the NMDS-SC solution would be complex and challenging. I needed the confidence arising from sound legal support.

I have an 'expert' friend from outside social care, who works in marketing for a large supermarket. When thinking through the NMDS-SC in the early days I was able to draw upon his knowledge of that sector and learned how they know what their customers want and are provide it. From my discussions with him I was able to develop the store card analogy described earlier in Chapter 1.

From another friend who is a 'city' IT lawyer, I gained some good advice about the legal aspects of procuring IT developments. Skills for Care engaged successful specialist legal advice, something we also tendered for. This helped us establish a very detailed contract with the developer. I was advised that the effort made to get a good contract was essential. I was also told that the art of a good contract is that it remains in the drawer, simply as good insurance.

Building a Team

My role in Skills for Care meant I was able to pick the key people who become the Skills, Research and Intelligence (SRI) team in Skills for Care. These individuals were selected and brought in (sometimes from other industries such as market research, data analysis and health) because they understood the vision and showed a passion to make it happen. I developed trust and team work as important characteristics in the SRI team as discussed by Dyer et al. (2007) and Maxwell (1993).

I never really recognised or understood fully, until the procurement process began, the importance of supporting the system, and the need to provide resources like a telephone helpline, to end users. This was something that Skills for Care took time to recognise. Lack of support could have brought down the whole project. As mentioned earlier, though demand was initially overestimated, helpline support has now become central to the organisation and remains a channel that engages some small employers with Skills for Care for the first time.

Development

Last but not least, while gaining support for this idea I knew I had to find some early supporters. Some people were quick to recognise the significance of my mission for a solution to the poor information on the social care workforce. I needed others who could see the vision and the potential but also could provide me with solace at times of difficulty. I gained that from two individuals in the DH. With them I shared a good executive relationship and developed a trust with both individuals (Maxwell, 2011). Both individually and together, these two powerful players remained involved and were of great support to me, as I felt that they believed in my ideas and my ability while challenging me through out.

Concluding Comments and the Future

The NMDS-SC can be used to build scenarios for the future (Hussein, 2009-11; Fenton, 2011). It has been used by policy makers (DH, 2010b) at all levels. Social care faces challenges and needs to do some things differently (Dilnot Commission, 2011). We now have a better idea of who the workforce are and of their individual skills. The NMDS-SC confirms that social care is a large, low paid workforce and it is for others to argue that should have more significance in our society. In my view, corporate, back-office driven social care is not the answer. Local and community inspired provision of social care must return. Local communities and individuals require understanding of the needs of their area; akin to the current trends or social movements, encouraging the use of locally sourced food and for food air miles to be reduced. All this can be informed by

the new starting point provided by the NMDS-SC, as we better understand the skills and characteristics of the current workforce.

In gaining support for and engagement with the NMDS-SC, we targeted those we knew to be good, strong, proactive employers. I have a strong suspicion that, in time, employers who use the NMDS-SC fully will prove to be strongly correlated to those who are recognised as good employers. I predict this will be something that will become a characteristic that inspectors and observers will look for and possibly customers too.

There is interest in using the model of the NMDS-SC, elsewhere. Other UK countries, including Wales and Scotland, are watching its developments carefully. The model would also be possible to adapt to other labour sector, because elements, such as job roles, could be easily changed. Other elements of the NMDS-SC are easily transferable and the system could cross sector boundaries. The experience of studying the implementation of the NMDS-SC offered some messages for those implementing LeaRNS (https://www.learns.org.uk/) which is another cross sector development around practice placements for student social workers and others in training.

Creative Use of Data in the Future

At the end of April 2010, 29,290 care providing locations (employers) in England had submitted NMDS-SC data and 64 percent of these had submitted or updated their records in the previous 12 months. In April 2010 the NMDS-SC online held 505,233 worker records. At the same date, April 2010, 150 out of

152 LAs had engaged with the NMDS-SC to some extent, and half of these LAs had been approved to use the bulk upload tool (personal communication from Skills for Care).

These figures indicate that this is a system that is here to stay. It represents a significant growth in data availability and an improvement on the size of the first batch of data (Eborall & Griffiths, 2008). It heralds a substantial change from the data sources previously existing in social care, none of which were complete or comprehensive (Eborall, 2005).

The NMDS-SC provides much data and in turn this could help make improvements in the social care sector. For many years the private company Laing and Buisson (http://www.laingbuisson.co.uk/MarketReports) has been the sole source of data on social care and, through its handbooks, has sold this information commercially, such as its market report on domiciliary care (Mickleborough, 2011). Skills for Care's ability to control and own NMDS-SC data, by far the most comprehensive ever accumulated, will be a significant contribution to the knowledge base and will enable providers to acquire workforce information without having to pay for it.

Learning to Let Go

The past few years have been a long and exciting journey; sometimes thrilling, occasionally scary and on reflection, though this is something that I did not always notice amongst all the adrenaline, often hard. It has been a journey toward a clear destination, with great anticipation; but like all travel

experiences it has had some long and often mundane aspects, when it has been important to keep up concentration and where simply 'keeping an eye on the luggage' was of prime importance. Keeping the project going was my responsibility.

I know enough about travel these days to know that at the end of this journey I would have to let go and allow this now integral part of the work of Skills for Care to exist without me. I was only able to make the decision to leave Skills for Care because the tipping point of success with the NMDS-SC Online had been reached. It was established and had a majority of employers in the system. In truth, letting go is something that began some time ago, as I recognised early in the project that I could not do everything: letting go began when I started to take on a team that I could trust and lead (Lewicki & Bunker, 1996).

The NMDS-SC works. Is it a success? I set out to find a solution to collect social care data and therefore radically improve what was known about the social care workforce. I have achieved this and the NMDS-SC Online is a successful solution that leads the way in information held about a workforce. There is no other system and no other national data set covering all the employers and employees. It has the potential to influence many other sectors in the future. As stated in Chapter 3, there was nothing like the NMDS-SC when I began this research.

The information that social care strategy (and far less often strategic planning) was based on in the past has significantly improved. The most accurate analysis

of the social care workforce is now available. This is a great deal of difference between the first report from Eborall (2005), that from Eborall and Griffiths (2008) at the beginning of the NMDS-SC online and the latest report of all (Fenton, 2011), as information has continued to be gathered. If it is supported, the system can improve, as its use in both the House of Commons, the House of Lords and other specialist committees demonstrates (Hansard, 2005; Unison, 2008). Other citations (DH, 2009b; DH, 2010b) also demonstrate the importance of the NMDS-SC.

Social care workforce information is now available and plentiful. Although, upon reflection, some elements of the work and this thesis might have been done differently (as related in the limitations section above), my professional quest has been a success by most measures.

Conclusion

Identifying a problem and even recognising a solution to the problem does not guarantee anything. The complexity of interested parties in social care is in itself a 'wicked issue', as noted by Clarke and Stewart (1997), in the sense of being perennial and difficult to resolve. Clarke and Stewart pointed out that the situation of complex interest groups is solvable, or at least capable of solution, by a mixture of common sense and ingenuity. These approaches seemed to resonate with those I adopted.

All players and stakeholders in the social care sector have their own interests. It is necessary to consider the potential perspective of a small individual

employer, who may think that filling in forms and giving information are a waste of time, even imposing on their personal privacy. Alternatively, there is the perspective of the sector-leading organisation, whose managers consider this development not for the overall benefit it will give, but over the short term; and who are willing to engage despite the 'boat rocking' their apparent support for this might create. Getting to grips with and meandering my way through the politics of change has been the greatest learning point in developing this major project.

I researched and developed carefully to make the solution work. The writing of this thesis has been a labour of continual commitment whilst working full time throughout. I found a pathway to gain and keep the support of my own organisation whilst acquiring government approval and resources (through the DH). This was achieved through outlining the solution and how to develop it, but also though networking with and even 'courting' stakeholders, especially key individuals and leaders, and allowing them to build up confidence in me as a 'champion' of this change (as mentioned earlier). I had to stand by my own conviction and preach the potential of the system continuously, from the germ of an idea through to the full development of the costly electronic online system.

When I look back at the diagram I drew in 2003, of the sector and all of its complexities (Appendix 1), I could not have envisaged the journey ahead. I was naive to the resistance that would emerge. Looking back, in my view, the greatest resistance emerged from organisations and key individuals' personal standpoints or ambitions, and not from any real disagreement with the idea of

an NMDS-SC. I believe that good, simple ideas can succeed. But I now understand the hard work that goes into them and the importance of leadership and being a champion. The inspectorates and government departments are naturally engaged in political debate and decision-making throughout any such development as the NMDS-SC, many needing to balance their commitment to change against their own priorities and organisational imperatives. They are generally risk-averse (Harwood et al., 2009). This unevenness culminated in the need to establish a joint statement of support for the NMDS-SC in September 2007. This was related to the government inspectorate's failure to link their own Annual Quality Assurance returns to the NMDS-SC in the previous April; thus ensuring that the potential to link up data could not be realised for yet another year, until April 2008. More recently the NMDS-SC has become the required means of collecting children's services workforce data (CWDC, 2008).

In time I understood my ownership and responsibility for the development of the NMDS-SC (I was recently introduced as 'the father and the midwife of the NMDS-SC'). My research and increasing knowledge and awareness (Mälkki, 2010) helped me to proselytise my idea where necessary (Glasby, 2011). I learned to develop a far better strategic analysis of situations and understand more about what motivates others by understanding their position. What is good for social care or health is not always what prevails.

I found most difficulty being patient. My own enthusiasm, passion and conviction for the need for the NMDS-SC would sometimes make me frustrated when others were less enthusiastic. I had to learn the art of the 'long game' and

the skills of understanding the importance of my ego (my own and others) (Korac-Kakabadse et al., 2002; Horn, 2008). I believed that I had to make the NMDS-SC a club that everyone wants to join, some because they truly believe it is valuable and others because they think it is the place to be and they need to be members too. I realised that the precise tasks of gaining better information on social care were too specific a task for some. Many potential stakeholders did not want to be concerned with that level of detail. Key individuals and stakeholders had given me their support and that was what mattered. This was evident in their dialogue on the video (discussed in Chapter 5) where many of those participating asked me what they should say. Some listened and simply repeated much of what I had said. Despite this, the video was used effectively to stimulate interest at several events and has been viewed by thousands through the Skills for Care website (Appendix 15).

I began this project alone, like a man with a mission. I think that is how I was viewed by some in my own organisation at the time and, as I have discussed, I felt few of my colleagues took my task seriously until much further down the line. However, in the work setting, I gradually assembled a team which I selected with care because I knew the success of this whole project would be greatly influenced by the people who would work with me on it. I was then responsible for giving support, encouragement and plenty of space to other people to get on with aspects of the work. While taking responsibility for my staff I learned more on how to be a leader and a better manager. I needed more than just people who did it like 'just another job'. However, I did not have the

help of my team in writing this thesis and I was more bound by academic conventions in terms of what needed to be achieved. It has developed my theoretical (Andersen et al., 2009; Turner, 2009; Jackson & Parry, 2010) and practical understanding of innovation and its inherent difficulties in a complex area. The contribution of this thesis is its presentation of an insider description and analysis of a major development in adult social care in England. I hope it is a useful contribution to a body of knowledge that is set around improving social care workforce information and which has used the NMDS-SC as a case study of implementation.

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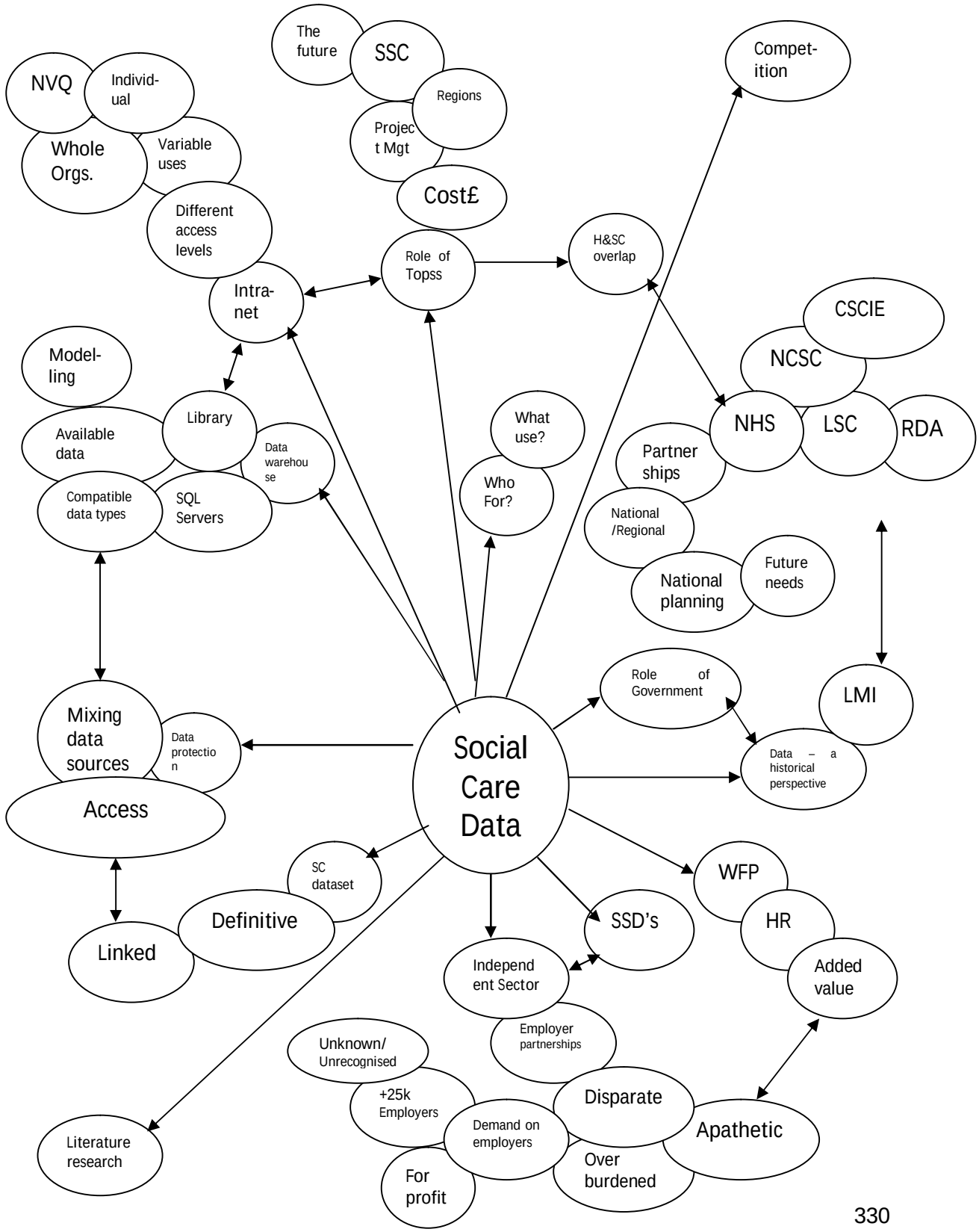
Index to appendices

APPENDIX 1: INITIAL MIND MAP 2003

Modernising Data Collection in Social Care



APPENDIX 2: PHD PROPOSAL

Francis Ward: PhD Proposal

October 2003: Professor Peter Huxley KCL

Provisional title: Modernising data collection in Social Care

Rationalising, systematising and modernising the process of collecting and subsequent use of data by the social care industry on it's workforce in England.

Ground breaking research into the developments, policy reform and key drivers in workforce data collection and the development of workforce intelligence in social care in England. Undertaken via my position as the 'champion' of this work in Topss England.

Aim

To investigate the pioneering role and impact Topss England workforce Intelligence unit has in establishing a groundbreaking data warehouse and library facility for social care data in England.

To consider this in light of the size of, and significantly disparate employers in, the social care sector.

Undertake a review of current data. This would include a quantitive and qualitative analysis of current workforce intelligence in social care in England: the role of key organisations in data collection such as Topss England, Governments Departments, The Employers Organisation, the National Care Standards Commission, Workforce Development Confederations, Learning Skills Councils and Regional Development

Agencies, as well as planned organisations when they come on stream such as SCIE and Topss as a Sector Skills Council.

Other key elements

Engaging the 25,000+ employers in the social care sector who are Independent, largely unconnected and diverse.

Understanding and planning organisational needs for data in the future.

Data protection issues explored.

An extensive literature search.

Data base developments and the use of intranet access and internet based applications:

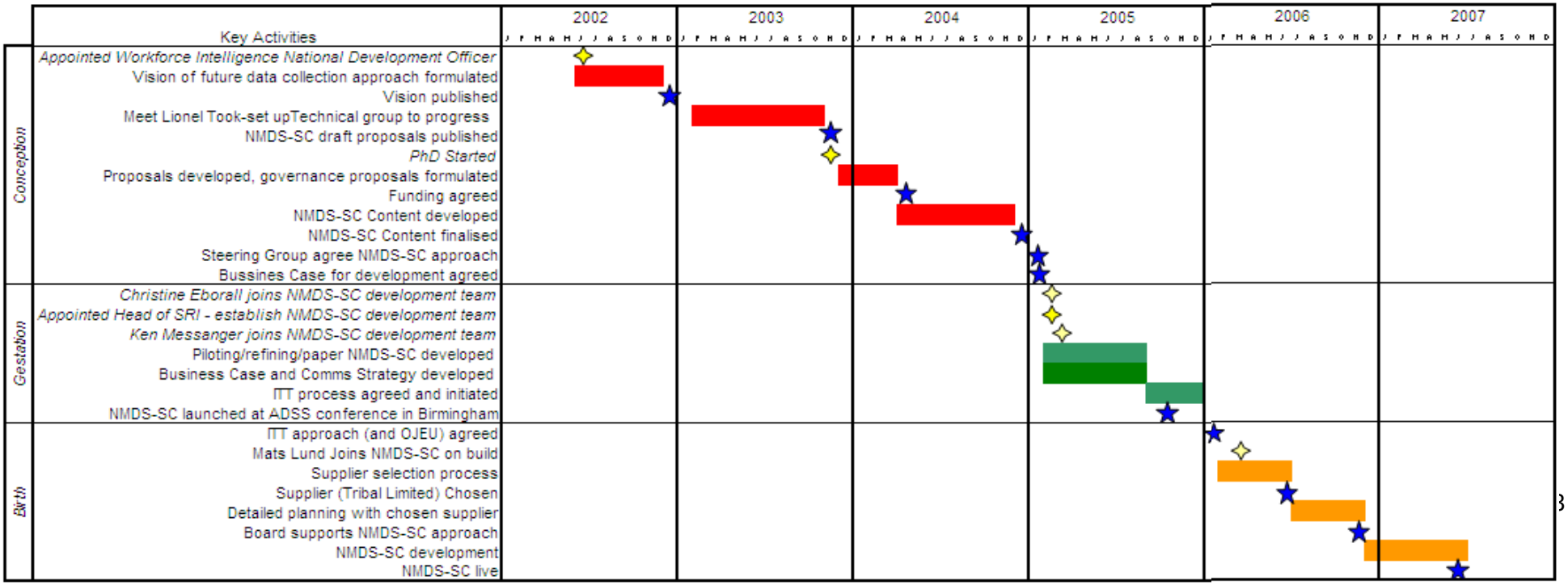
The use of modelling and forecasting for the sector.

The development of 'datasets' in the sector.

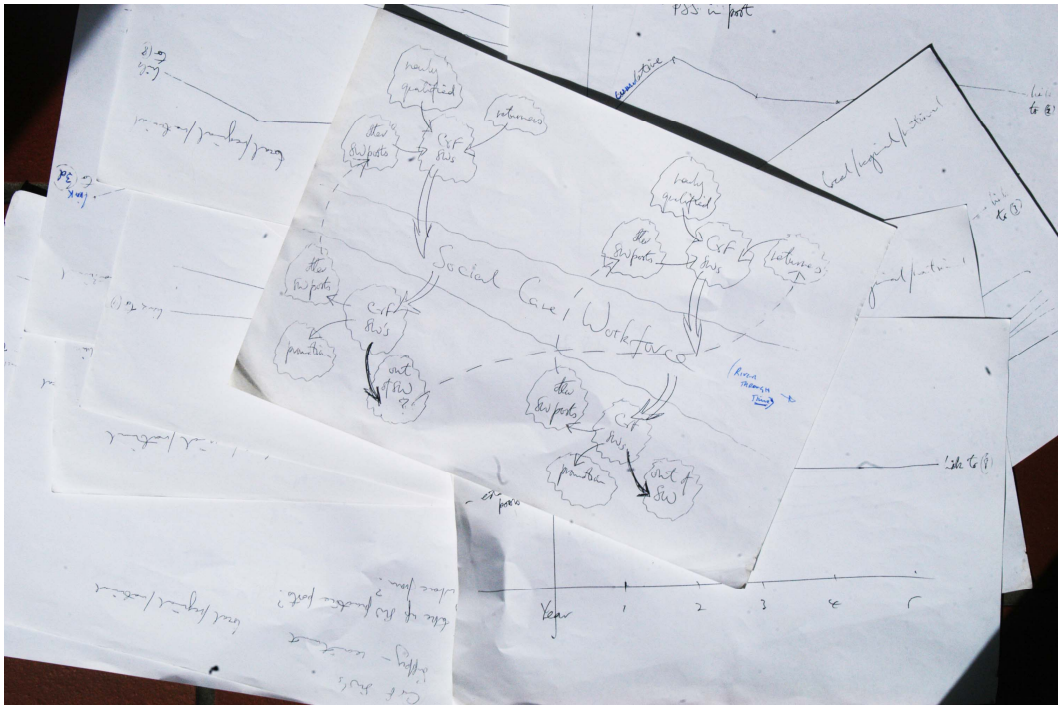
Project development and project management and planning for evolutionary progress.

APPENDIX 3: TIMELINE

The Development of the NMDS-SC - A Timeline



APPENDIX 4: MEETING LIONEL TOOK



Meeting with Lionel Took DH Wellington HS. 8.7.03

DH want a Staged Project developing.

1. An Annual Report of SCHR inc logical/other backdrop
This could be an extention of the CO1 report they commissioned in 2001.

2. Establish a P.Manager to work up a Data Housing System and Analysis of all data on SC. This should inc. EO. and WERU @ Kings - Pete Hurley.
P.M. To be established in TOPSSE and a) Establish Project Requirements b) costs c) timetable d) Issues e) Work

3. Scoping exercise to be set up asking HASCWF@WD
does what and why b) how they use what they get
c) Formats info stored in d) is it available for access. e) data P. issues
f) location of data g) what data/info collection is planned in future
h) Identify any gaps known i) via TOPSS develop a process to fill these gaps. j) Why is data needed k) how do they want and what types of analysis.

- Establish a start date and parameters of Scope.
- Keep an Eye on the future and the needs of the NHS and the Electronic Health Records development.

A Police Skys Session - to provide the link and the vision to the future and ESR / Social Care.
Ideas around Setting up a days workshop.

Fmw.

APPENDIX 5: CONFERENCE PROGRAMME

National Minimum Dataset

Systematically collecting Social Care Workforce Information

Reducing demands on employers

Seminar programme

16th November: London (Royal Statistical Society)

2nd December: Leeds (Queens Hotel)

15th December: Bristol (Armada House Conference Centre)

10.00	Registration and refreshments	
10.30	Welcome and aims of the conference	Andrea Rowe (Leeds) Vic Citarella (Bristol) Arthur Keefe (London)
10.40	Strategic context: why a National Minimum Dataset for social care? (NMDS-SC)	Lionel Took
11.10	NMDS: context, background, benefits & progress	Francis Ward
11.30	Benefits in practice: using information locally, regionally and nationally	Prof Peter Huxley
11.50	The future is bright it's a NMDS-SC!	Francis Ward
12.05	Introduction to afternoon workshops	Chris Bell
12.10	Key issues: brainstorm in groups of 2-4 key issues to raise at workshops	Chris Bell
12.30	Buffet lunch	
13.15	Workshops to discuss: Issues generated in previous session Content of draft NMDS-SC	Groups of 12-15

	Data collection issues Practical issues: collecting data from agency staff, foster carers, directly paid carers etc	
15.00	Refreshments	
15.20	Key issues from workshops Solution-focused discussion Summary Actions	Francis Ward Chris Bell
16.00	Close	

APPENDIX SIX: CONFERENCE SEMINAR OUTPUT

Support for the NMDS-SC: Did the NMDS-SC have the potential to give useful information to the sector?	***Some of my thoughts and responses to these comments.***
An overwhelming "yes" as long as it's handled appropriately	An affirmation that the NMDS-SC was on the right track and a clear warning of the pitfalls in getting it to the 'table'.
Should cut down the amount of work in completing multiple surveys - **if** the NMDS-SC overcomes the need for many of other surveys.	This was a signal to make sure the NMDS-SC in time demonstrates substance and the DH and other recognise the need to stop others and the potential savings possible.
Will provide a useful workforce-planning tool helping people plan better at all levels across all social care (locally, regionally, and nationally) and aid planning between sectors.	A confirmation of what I believed.
Should provide usable information at all levels: locally - high level of detail; regionally - more of an overview; nationally - a high-level overview	
Standardised and consistent information, as opposed to multiple surveys which do not correspond, must be good	

Will help in targeting money to where it is really needed; also useful during bidding for funding	
Potential to become a "directory" for the whole social care sector (including providers, purchasers, training providers)	The concept of all social care in this directory is a powerful image.
Comments on more operational issues	
Must be adequate resources to allow the NMDS-SC to work - data collection, recording systems, analysis systems, communicating information. Resources needed at local level. Think about a body equivalent to the NHS National Workforce Unit (SSC role?), otherwise, will be difficult to do anything useful with the data. Need to consider who "owns", manages and is responsible for the system. These sort of decisions are needed sooner rather than later - and they need to be communicated.	This was good direction as to what was needed to come next having completed this fairly early task of getting a data set agreed. The work was far from over. I was always clear the further investment that the sector needed to make to provide a proficiency in both collecting, storing and using the data in a way that would make it worth the effort. All of this was risky as I knew that the argument to undertake this commitment was far from won.
Should be mandatory for all; and must be kept up-to-date (e.g. yearly).	I agree. Sadly I had been told in no uncertain terms that government did not have the stomach for this.
Need just one return which replaces most of the data collection that goes on currently. Need to consider carefully the change from present collections to the future collection - needs to be seamless.	Confirmation we are doing the right thing.

For many organisations it will take time to complete the first time, but if the data collection system is "right", in subsequent years it will only be a matter of updating - must aim for this.	This is where we are at present (September 2006) and the evidence employers are telling us is exactly this.
Need an unambiguous statement about the purposes of NMDS-SC (in particular in light of perceptions and suspicions): what it will be used for; how it will be used; who is going to use it; who has access (needs to be transparent) - different people/organisations need access at different levels.	The 'what's in it for me Documents' are partly aimed at this focus. The detail of reporting and access prescribed in the build of the electronic system has been a response to warnings about access.
Need to engage employers, social services, unions and other stakeholders in this debate; present an operational plan to them, show them the advantages; "galvanise the sector to buy into it". In particular, need to sell the idea to senior managers (especially social services).	Social services have proved a hard nut to crack, largely owing to their natural lethargy, compounded by limited resources and a distinct lack of drive to modernise all too often demonstrated. The project of engagement discussed responds to this further. Other elements of work have gained management support. Acknowledged elsewhere.
Need to decide exactly what staff will be covered by NMDS-SC (boundaries with health and education may not be entirely clear). Need to define what an "employee" is (e.g. is someone working for just one hour an employee?). If try to include everybody, then it could appear that there are far more people working within the sector.	Double counting and concrete decisions about this were made before it was launched.
Need to think about both data protection and freedom of information acts;	The permission to share data belongs exclusively with the employers and

also Caldicott requirements. Some of the data is sensitive, need adequate protections for this data - and people need to know that it is going to be protected and who will have access at what levels.	permission with their staff. All other identity is not known in the system as developed.
There is likely to be collected information that could be used outside the care sector (e.g. people working without a work permit; inconsistencies with the working time regulations). How would requests for information from other parties be handled (e.g. National fraud initiative, student loans Company, and financial institutions)?	See above as identity not known. Larger 'faceless' data analysis could be made available. This would be a decision to be made within SfC when it arises. The sale of data to such bodies as unassignable raw data is possible.
Quick wins are required to keep attention focussed, otherwise interest in completing the data set will diminish - need to deliver tangible benefits locally, regionally and nationally as quickly as possible; need to show linkages between information, planning, training, funding, outcomes and quality of provision.	This was largely the reason that the gap between agreeing a data set and getting it into the public domain was deliberately kept short with the introduction of the very successful paper/CD-ROM exercise called 'the interim solution'.
Need to get a good response for NMDS-SC to be useful - therefore needs to be easy to complete and people need to know how it is going help them. Need a helpline / help e-mail available when people are completing the NMDS-SC. However also some feeling that fewer returns are a valid trade-off against quality of data.	Customer service /helpline developed as part of the Online system. I always knew paper was never going to be as easy as the vision I had on the online system but I knew good marketing and good branding of it using a design that could be made as user friendly as possible were essential.
Most organisations with good quality information systems will hold most of	The NMDS-SC has to those 'good' organisations been a weather check. They

this data already; if they don't, then NMDS-SC will help them - this should be seen as a selling point.	have been able to say we have this it's easy or it has given them a nudge where they miss certain things. Arrival and exit information is a good example.
Will there be a "census day"? This is the only way to get accurate figures and information - but perhaps that doesn't matter, at least to begin with even somewhat out of date information is better than what we have now. Need to consider affect of financial year ends on the number of staff employed.	Decision was made to make it a census week to allow for organisations who may not work particular days. Last week of September. This fits in with the LGA/EO, which has traditionally collected their data on 30th September cut off day. Electronic system is 'live'.
Need to ensure a comparability between information collected for care and that collected for health - try to stop confusion/conflict further down the road.	Close ties have been forged to ensure data items link with the electronic staff record.
Must be careful not to get double counting, therefore need unique identifier for each member of staff.	Unique identifier required lots of effort and use of NINO has not been without its critics. Post codes and Dob also.
Need to decide who is going to complete it, employer or individual employee? Probably best for employer who should have all of the information needed on their employees - if they haven't got this basic level of information, they should have! If an employer has multiple locations, need to collect separately from each location. Need to confirm and ensure confidentiality.	We went with employers in the end. We did this for both reasons of logic and simplicity. We wanted to get as many employers in the system as soon as possible and the request for the organisational information first was deliberate. We anticipated that once in they would use it and add to it and some 'sticks ' and carrots 'would come into play. We also knew it was logical for employers to enter employee information with permission in

	many cases.
Guidance notes are essential (need to keep these short as possible, often they become bigger than the survey itself); need to be in plain English.	Plain English support accompanied the paper 'interim solution' and improved simpler drop down help developed as part of 'Online help'. Also job roles booklet developed has had other spin offs. (First time SC has had 27 job roles defined so that all other jobs fit under these).
Get the NMDS-SC template out as soon as possible so people who collect data can start to move towards it.	Yes. We knew that getting the format out early was essential to get it into people's thinking.
Gather information from people who are forging ahead: what is being done, how is it being done, is it working? Need a couple of "real" pilots. A phased start to full data collection is OK. "NMDS-SC should be seen as a journey".	And what a journey! Pilots undertaken. The keen and front runners came on board at the beginning. Other pro active organisations deliberately have waited for the 'online system' so they can enter their information in a process they understand will be more user friendly than the paper exercise.
Think about linkage with other systems (induction registration, NHS, GSCC, LSC, CRB).	All other organisations have been included I its development in the hope that they will take note and not do different things? This has largely appeared to work with the odd exception such as CSCI (ref earlier) who then put it right. The link to the GSCC is a real possibility. It is currently under discussion but the possibility that employees / employers on their behalf

	with permission can send the 8 or 9 data items in the NMDS-SC off to the GSCC to half complete their registration process is a real possibility either as a print out signed with a check or electronically.
Anxiety about a 2005 implementation - there is not enough planning in place at the moment. However others think that NMDS-SC needs to be fully operational as soon as possible.	The 64 dollar question, when to go? We went!
Learn from what NHS have done, in particular their mistakes and avoid these.	I have lived in fear of running over time and over budget and creating a white elephant. All these fears have helped me focus my mind.
Specific questions asked of the version of NMDS-SC used at conferences	
Wherever possible try to use the same definitions as SSDS001.	SSDS001 heavily considered throughout.
Suggest remove "approximate" from questions.	Questions were all revised to remove these grey areas that naturally enter during development.
Need to define what is meant by many of the terms (e.g. "vacancies").	All included in 'help'.
Need to think about how to make questions more precise, some categories are very general at the moment.	All questions were given a thorough overhaul before being finalized.

Need to make sure that "employer" is linked to "employee".	This was essential and built into data collection process for both paper and Online system. Data Tracking works as a relation of orphan to parent data.
More use of free text to allow providers to embellish questions – though harder to analyse.	Use of free text has had to be limited and responses given under strict guidelines to allow for good data recording and analysis.
Some of the fields may not apply to some organisations - perhaps need to identify those fields which are compulsorily and those which are not; also issues with some very small organizations.	Data fields are far simpler now in the online system as it simply moves you to where you go and you don't see what is not relevant if it is not required. Paper 'interim solution' had more gaps in pages not required or unfilled. Online system also saves and allows person completing to return at any later date.
A feeling by a minority that the current NMDS-SC is too ambitious, trying to collect much; better to phase it in: basic information first time round, then more next time etc. If this was done, then regional partnerships could handle the first phase; possible involvement of Section 31 partnerships? Perhaps set final target for 2008.	In the end this amount of investment and effort had to have sufficient to make it worthwhile. Criticism would have been significant if it had been half the size. It is still a 'minimum' data set not a 'maximum' one. This criticism appears to have disappeared now.
Is there anything missing?	
Need an overall definition of "social care" – will help define the footprint of NMDS-SC (consider new SSC: wider than current Topss England? Children	Definitions were included in help and data items were included for children services which they more recently formed CWDC have oscillated in their

and young people? Youth Justice?).	interest of, culminating more recently in their appreciation of the data it has collected so far and renewed investment in it.
Possible that "Line number" on SSDS001 includes more useful information (line number is a combination of focus of provision, service user group and staff category). Likely to be OK for LAs and Trusts but doubts about whether it would transfer to the independent sector.	Issues raised on service, organisational definition and service provision all had a strong influence on the final wording.
More detail about children's services, including the new roles - though will this still be relevant if Topss is leading on the NMDS-SC?	As mentioned above CWDC backed the NMDS-SC and items for children have value.
IIP status of organisation – "Do you have IIP status?"; "Are you working towards IIP status?" (would also be useful to know if IIP status has had any impact)	Included.
Percentage of funds/turnover spent on workforce development/trading.	Excluded?
Identify workflows between sectors.	Where people leave to go/ where they come from included.
Questions about practice learning?	Included?
ESOL data / needs.	???

Need to think about collecting information from charities/voluntary organisations; how handle casual staff/volunteers?	Temporary and informal employment included.
Date of last CRB check.	CRB checks not included as they are the responsibility of elsewhere in government.
For social workers, the registration number is important.	GSCC collect this?/not sure if in-don't think so?
Information about people 16-18 who work in homes but who can't deliver care.	Yes.
Information about throughput of students / student placements (particularly useful for LRCN).	yes
Is there anything included at the moment, which could be left out?	
The shorter the questionnaire the more likelihood of completion; however it seems that almost everything needs to be included!	Once again the 64 dollar question- what's in what's out. Amazingly most items were self selecting and only a real few caused major consternation. Always had to be the 'minimum' amount and remain achievable!
A much smaller NMDS-SC could operate for very small organisations: three absolute minimum questions for each member of staff (it is essential to collect information for each member of staff) are: age, qualifications, job	Very small organisations simply missed lots out on the paper process. The electronic one does not allow them to see what is not relevant as they are taken through the process according to their choices.

role.	
How best to collect information from organisations	
Collection should be mandatory for all – for care homes should be an employer responsibility.	Shame it is not. Other 'sticks and carrots' have come into play.
Should be a "carrot and stick approach". Ideas include: payment for submission of data (£50-£100); access to funding (e.g. Topss; SS) only if NMDS-SC is completed; social services only contract with organisations that have completed NMDS-SC. It will then soon get into the "psyche" and collecting it won't be an issue - if people continue to see the benefits and it cuts down the number of surveys.	The link to DH TSI funds helped here. ADASS have recommended contracting with compliant organisations. It remains to be seen if the SSD's will have the teeth to follow this though? Benefits are already being seen as briefing documents come out on data. Deeper analysis will follow as process and other government bodies have recognised its existence and sought data. (ECCA/border and immigration agency of the home office).
Ensure that organisations have access to data and feedback how the NMDS-SC is helping the sector / improving quality.	This is starting to happen and the Guardian article 17.10.07 and supporters of the NMDS-SC increase and develop the courage to say what it is doing for them.
Need to give organisations time to prepare for completing the NMDS-SC. Collect as much as possible via ICT systems (ideally an online database). Think about ways of getting IT equipment into organisations that do not have it. Likely to need some capacity building and support (including	Time and a fallback solution are all in the design. The significant increase in the use of broadband Date: 29 May 2003 BBC News online

technical) in some organisations – especially very small ones.	According to new figures from Nielsen//NetRatings, the UK experienced the largest increase in high-speed internet connections in Europe last year. In the 13 months from April 2002 to April 2003, the number of European surfers using high-speed connections - including DSL, LAN and cable modem connections - grew by 136%, with the UK experiencing the largest increase at 235%. 28% of European internet users are now connected at high speed, a growth of 14% from April last year, but still some way behind the US and some far eastern markets. And (Broadband now accounts for 64% of all net connections in the UK, according to figures for December released by the Office of National Statistics (ONS). http://news.bbc.co.uk/1/hi/technology/4736526.stm (2006) in workplaces over the last 5 years has been of great benefit here to this project.
Need to collect data locally; aggregated to regional and national levels - in this way, there will be local ownership and data for all purposes. Need tangible benefits locally, regionally and nationally.	Data set analysis allows for this right down to post code.
Most considered that CSCI have a central role in collecting NMDS-SC data, no one else has the infrastructure, and also CSCI operates locally. Inspectors could collect data (or require it to be provided); make it part of care home registration. Need a cooperative approach with CSCI; need to be seen to support NMDS-SC. However, using CSCI could mean data was collected	Inspectors have agreed to ask for the bits the NMDS-SC collects that they need and use it as part of their AQAA process. Very public handshakes have taken place and they have been around the table all through its development, since day one.

from different organisations at different times. Some organisations not registered, therefore would CSCI have data on these?	Those who are not CSCI registered (domiciliary Care providers for instance) are filling it in.
However, some comment that many organisations lack confidence in CSCI and that linking NMDS-SC to CSCI may cause problems. An alternative mentioned by one group is to collect information through Topss regions, perhaps involving the Learning Resource Centre Networks; perhaps some issues here with relationships between Topss and social services departments.	We decided that the difference between the organisations should remain and that CSCI do inspection and we do workforce development as the SSC.
Also some comment that there needs to be a variety of data collection techniques operating in a synchronised manner: "Develop a set of tools for regional/local groups to use for collection/analysis. CSCI in conjunction with other organisations. Push down to the 9 regions and areas within them. LAs and care consortiums to support other organisations. Define a smaller NMDS-SC for very small organisations? Very small organisations are likely to need additional support - e.g. questions completed via a telephone survey.	A range of modes of delivery is designed to always be available. We know the 'online system' will always be favoured by those who get to try it as it offers in 'live' terms so much more will be easier to use and generates an immediate return.
Social services departments hold much of the NMDS-SC data for their own staff and for their own homes - this could be collected, but be careful about overlap if collected also through CSCI.	Decided it was fraught with all kinds of problems none more so than the difficulties we have had in getting data out of them at all. The 'Bulk-upload' aspect of this development should meet all their needs but once again I know there are those who will with vigour and those who will need

	pushing all the way.
Need to collect data annually - so that NMDS-SC will be as up-to-date as practical.	A 'Live system' with a guidance around September census point.
Use ICT data collection wherever possible (but recognise not all will have access, therefore need other methods including paper as a last resort - it will be costly to do it this way).	Discussed throughout.
Implementation issues	
Capture as much data as possible – don't be too concerned that it's not going to be complete (at least initially).	Getting employers into the system was seen as very important. An aspect of their maturation/ arrival/ passing into?
Need to consult with a selection of agencies, social services, foster carers, advocates to find the best methods.	Wide consultation through groups and events undertaken.
Money for most of these is coming from social services, therefore they should have information about who is receiving what – but not necessarily the details needed.	Not sure if I understood this point. SSD's will get their regional/local and national data.
Agency staff: either include on employers return with the period identified, or go to agencies. This is one area where a unique identifier is essential to	Agencies were always hard to crack. NMDS-SC asks about agency staff.

reduce double counting – otherwise could be real skewing of data.	
Foster carers: from the LA approving them or the LA for whom they were fostering. Also CSCI data? Private fostering agencies? Just try to cover those fostering at a particular time or all those approved/ registered?	Fostering left out- a bridge too far?
Direct payments: a particularly difficult area – information from local authorities / social services providing the direct payments. Could be left out first time around.	Seen as very important and the NMDS-SC facilitates its gathering.
Also consider supported living.	Missed the cut?
Need a system similar to NHS system whereby non-UK qualifications are listed and compared to equivalent UK qualifications: a role for Topss in collaboration with GSCC and NHS? Keep it simple!	Done exactly this.
Use GSCC for social work qualifications; but for social work...?	See above.
An options box for recording any non-UK qualification regardless of what it was.	Records this.
Potentially the greatest source of difficulty for employers and their staff, although reasons for it recognised; perhaps better to leave out than cause	Considered too hard to leave out. Included; it ask employers for their pay rate. Surprisingly comprehensively completed in returns so far. Perhaps it is the

problems. Pay may not be recorded honestly. The independent sector is not likely to cooperate over pay. However, knowing pay is important! Employers are bound to be concerned about who is going to know what they will consider to be commercially sensitive information.	case of this being confidential and the local/regional /and national averages inform employers too and help them understand R&R?
"Salary" is probably better than "hourly rate" – could have salary bands.	Hourly rate was chosen as it makes more sense to social care sector.
Several thought this should be compulsory – if optional it will not get completed and therefore be less useful.	It is part of the NMDS-SC and the norm is to expect it all to be completed. CSCi will ask those who have not up dated recently or those who have missed sections to complete those 9 for the bits they require).
Need to define carefully what should be included (part time, casual, benefits, London weighting?).	Once again the effort to produce good clear guidance was important and this does this.
Important for workforce planning that individual's data is collected (also important to reduced probability of double counting, e.g. where someone works in several organisations – high likelihood of this). Need to be able to track individual movement through the sector over a period; can only do this with individual data.	Included and developed into the 'online system'.
Need a unique identifier - general feeling that national insurance number is best. However an alternative noted by several: "unique identifier should be based on coding for an occupation using the existing SSD codes. Once	Discussed above - included.

broken down by the relevant employment group then the employer could assign a specific code to each member of staff prefaced by the SSD code". Other alternatives: NHS number, LA staff number or GSCC registration number for such staff.	
A small minority of groups considered that data should be fully anonymised; could be conflicts between employee confidentiality and the employer completing NMDS-SC.	Data anonymised to all except for employer and employee and unless they choose to share it with others.
Concerns over (non-?) recording of illegal staff. How would the casual workforce in the independent sector be handled?	The NMDS-SC asks for those who work in the establishment and does not ask if they are legal or illegal.

APPENDIX 7: PROTOTYPE VERSION NMDS-SC

National Minimum Data Set for Social Care (NMDS-SC) : draft Version 13: 20 March 2005

Data Item: no.	Data Item: name	Sub-Item no.	Sub-Item name	Classification	Draft outline definition / explanation (once outlines are agreed, detailed definitions will be developed and will be contained in a separate guidance document)
1	ORGANISATIONAL INFORMATION				
1.1	Organisation data	1.1.1	Establishment identifiers	Local organisation name	Name of business or organisation at this establishment. Definition of an organisation: An organisation is a group of people who work together in a structured manner to a common purpose. Some organisations have the legal status of employing organisations.
				Parent organisation name (if any)	Name of parent business / organisation, if applicable
				Address	At this establishment
				Postcode	At this establishment. May also be necessary to record local authority area for non-local authority care providers because post codes don't align

					completely with local authority boundaries.
				Telephone no.	At this establishment
				Email	At this establishment. If no email address for the local org as a whole, use that of the manager or administrator.
				CSCI registration number(s)	CSCI registration number(s) applicable to this establishment, if CSCI-registered
		1.1.2	Completion Date (Establishment)	Date to which the NMDS-SC data for this establishment relates.	For many employers this will be the date on which the questionnaire/form is completed, but for large employers data completion may take some time and therefore all data should refer to one date i.e. the Completion Date (Establishment). It is envisaged that the dataset will be completed at least once a year, possibly on a specific 'Census date'. In the statutory sector this could be 30 September, to fit in with existing data collection schedules. The name and job title of the person responsible for completing the NMDS-SC would also normally be collected, so that any queries arising can be checked, but does not form part of the dataset.
1.2	Type of organisation			Statutory: a local authority	The central support staff teams or social work teams of the local authority social services department, i.e. non-direct care.

				Statutory: local authority owned	Care settings owned and operated by a local authority, e.g. day care centre, care home.
				Statutory: health	Operated by the NHS, a Primary Care Trust, a Health or Care Trust or another public sector health service organisation
				Private	Private sector/operating for profit (even if all services provided are procured by local authority/ies)
				Voluntary	Voluntary sector/'not for profit'/non-profit distributing (even if all services provided are procured by local authority/ies
				Other	Another type of operation, including joint ownership (further details will be requested)
1.3A	Service provision: all types offered / provided	1.3.1	Adult residential:	Care home with nursing provision	Covers the complete range of types of care offered / provided. The main type offered / provided is collected in Data Item 1.4. CSCI descriptors / definitions to be used or incorporated.
				Care home without nursing provision	CSCI descriptors / definitions to be used or incorporated.
				Specialist dementia care	CSCI descriptors / definitions to be used or incorporated.

				Adult placement	CSCI descriptors / definitions to be used or incorporated.
				Sheltered housing	Provision of sheltered/very sheltered/extra care housing; assisted living; supported living for older people and adults aged 18+
				Other	Another type of residential provision for older people and adults aged 18+ (further details will be requested)
		1.3.2	Adult day:	Day care	For older people and adults aged 18+
				Other	Another type of day care provision for older people and adults aged 18+ (further details will be requested)
		1.3.3	Adult domiciliary:	Domiciliary care	Domiciliary care / home care / domiciliary care agency for older people and adults aged 18+. CSCI descriptors / definitions to be used or incorporated.
				Home nursing care	Home nursing care / nursing agency for older people and adults aged 18+. CSCI descriptors / definitions to be used or incorporated.
				Domestic services	Domestic services / home help for older people and adults aged 18+
				Meals on wheels	Meals on wheels for older people and adults aged 18+
				Other	Another type of domiciliary care provision for older people and adults aged 18+ (further details will be requested)

		1.3.4	Adult community:	Carers' support	For older people and adults aged 18+
				Short breaks / respite care	For older people and adults aged 18+
				Community support	For older people and adults aged 18+
				Care management	For older people and adults aged 18+
				Disability adaptations/assistive technology services	For older people and adults aged 18+
				Occupational / employment-related services	For older people and adults aged 18+
				Information and advice services	For older people and adults aged 18+
				Other	Another type of community provision for older people and adults aged 18+ (further details will be requested)
		1.3.5	Children's	Care home / hostel	CSCI descriptors / definitions to be used or incorporated.

			residential:		
				Family centre (residential)	
				Foster care	CSCI descriptors / definitions to be used or incorporated.
				Adoption	CSCI descriptors / definitions to be used or incorporated.
				Residential school	
				Other	Another type of residential provision for children aged under 18 (further details will be requested)
		1.3.6	Children's day:	Day nursery (full day care)	Ofsted definitions to be used
				Play group/pre-school	Ofsted definitions to be used
				Out of school club	Ofsted definitions to be used
				Holiday club	Ofsted definitions to be used
				Crèche	Ofsted definitions to be used
				Childminder	Ofsted definitions to be used

				Nursery school	DfES definitions to be used
				Primary school	DfES definitions to be used
				Secondary school	DfES definitions to be used
				Special school (day)	DfES definitions to be used
				Pupil referral unit	DfES definitions to be used
				Other	Another type of day care provision for children and young people aged under 18 (further details will be requested)
		1.3.7	Children's domiciliary:	Any	Any type of provision (further details will be requested)
		1.3.8	Children's community:	Fostering or adoption services	For children and young people aged under 18
				Child protection	
				Family centre	For children and young people aged under 18 and their families
				Care management	For children and young people aged under 18
				Information and advice	For children and young people aged under 18

				services	
				Other	Another type of community provision for children and young people aged under 18 (further details will be requested)
		1.3.9	Other type of service provision	Other	Any other types of service provision not covered by 1.3.1-1.3.8
1.3B	Service provision: main type offered				As 1.3A for the main care service provided by this establishment, i.e. the one which employs the most staff. An alternative approach would be to define 'main' as the service which provides care for the greatest number of service users. Views welcome.
1.4	Service user group(s) for whom care provided	1.4.1	Older people	Older people	Aged 65 and over.
				Older mentally infirm people	Aged 65 and over
		1.4.2	Adults	Adults with physical disabilities	Aged 18-64

				Adults with learning disabilities	Aged 18-64
				Adults with mental health needs	Aged 18-64
				Adults with sensory impairments	Aged 18-64
				Adults who misuse alcohol/drugs	Aged 18-64
				Other adults	Any other adults aged 18-64 (further details will be requested)
		1.4.3	Children and young people	Children & young people looked after	Aged under 18
				Children & young people with physical disabilities	Aged under 18
				Children & young people with learning disabilities	Aged under 18

				Families	
				Other children & young people	Any other children & young people aged under 18 (further details will be requested)
		1.4.4	Carers	Of older people	Of older people aged 65 and over
				Of adults	Of adults aged 18-64
				Of children and young people	Of children & young people aged under 18
		1.4.5	Other service users	Other	Any other types of service user not covered by 1.4.1-1.4.4
1.5	Service user capacity			Total number of service users for whom care services can be provided by the business/organisation operating at / from this establishment	Relevant measures include number of places for residential and day care services; registered units of care for domiciliary services; case load for community services. For CSCI registered providers this will be the registered capacity.
1.6	Number of service users on			Total number of service users provided with care services by the	Relevant measures include number of service users provided with care in residential and day services; number of units of care delivered in domiciliary services; number of cases worked on for community services

	Completion Date (Establishment)			business/organisation operating at / from this establishment during the past 7 days.	*(how feasible is this ?)* Past 7 days = the 7 days preceding the Completion Date (Establishment). Total number is the total number of individual service users provided with care services during this 7 day period, e.g. if 10 service users received care during weekdays and at the weekend 3 different ones received care, the total would be 13.
1.X	Total number of staff at this establishment			Nine [tbc] Social Care Job Categories reflecting National Occupational Standards and enabling matching of qualifications to job roles in social care. This is under development. Plus the following 4 Additional Job Categories: Administrative staff: secretarial/clerical, finance/accounts/	Number of staff in each job role employed by or who did paid work for the care-providing operation at this establishment in the past 7 days. Past 7 days = the 7 days preceding the Completion Date (Establishment). Include all part-time and full-time staff (headcount). Include temporary **and agency** staff in the relevant job categories they have been working in. The grouping of job roles into the 9 Social Care Job Categories is intended to enable matching of qualifications to job roles, and to enable developing new roles to be slotted into the appropriate category. For local authorities:

				HR/training, IT and other administrative roles. Ancillary staff: domestic, cleaning, catering, maintenance, premises management, drivers and other non-care staff. Students [paid or unpaid] on placement or work experience Volunteers [paid or unpaid]	A map of the SSD001 codes to the 5-8 Social Care Job categories is under development and will be provided. Employees in the administrative and ancillary Job Categories, only partially collected by SSD001, should also be included. Agency staff should be included. It is recognised that there is the potential for duplication between this Data Item and the Individual Employee Information part of the NMDS-SC, i.e. if an employer is able to complete the Individual Employee Information Data items for every employee, then Data Item 1.X is by definition also completed. However, it is anticipated that many small employers will be unable or unwilling to complete Individual Employee Information for every employee. In such cases, valuable information on the workforce would be lost unless Data Item 1.X, covering the employer's total workforce, has been completed. Data collection tools for the use of local authorities and other large employers will be developed which allow both data times to be compiled in one go.
1.7	Current number of			Using job categories and roles at Data Item	Number of vacancies in each job category at the Completion Date

	vacancies			1.X	(Establishment). Possible definitions of a vacancy: NHS definition: an established, budgeted or otherwise agreed post that is unfilled and/or could be filled by a person. [i.e. may no involve seeking a replacement. NHS also define a vacant post as one which currently has no staff assigned to it]. Social Services Workforce Survey definition: a funded post with no employee in post and for which a replacement is being or will be sought. This data item does not apply to the following types of staff: Agency staff Work experience / placement students
1.8	Number of staff starting during past 12 months			Using job categories and roles at Data Item 1.X	Number of staff in each job role who commenced employment at this establishment in the 12 months preceding the Completion Date (Establishment). Applies to staff in all Job Categories including agency staff, work experience / placement students and volunteers

1.9	Number of staff leaving during past 12 months			Using job categories and roles at Data Item 1.X	Number of staff in each job role who ceased to be employed at this establishment in the 12 months preceding the Completion Date (Establishment) Applies to staff in all Job Categories including agency staff, work experience / placement students and volunteers
1.10	Main sources of recruitment			Per categories below:	Number of staff starting during past 12 months (Data Item 1.8). There is no requirement to provide this Data Item for individual Job Categories. However, employers such as local authorities which can provide this data for individual staff category to be encouraged to do so..
				From adult care sector	From employment in adult care within the UK
				From childcare or education sector	From working within the UK with children: childcare, early years or education.
				From health sector	From the NHS or other health-related work
				From retail / shop / supermarket work	In the UK
				From other types of employment (not care, education, health or	In the UK. At present some types of care-related work e.g. probation, youth justice, community workers, housing officers would fall into this category.

				retail)	
				From abroad	From outside UK
				People not previously employed	Includes school / college leavers, first job
				Returners	People returning to work after 'career break' e.g. caring for young children
				Internal promotion / transfer / career development	Staff already employed either at this establishment or at another establishment within the same organisation, in some other role or function.
				Agency	For agency staff
				Student work experience / placement	
				Volunteering	People who were working (in care or other work) in a voluntary capacity.
				Other source(s)	Further details will be requested
				Not known	
1.11	Main reason for staff			Per categories below:	Reason for leaving = the reason why an individual's employment has been terminated or, for volunteers, why voluntary contribution has ceased.

	leaving				Number of staff leaving during past 12 months (Data Item 1.9). Only one reason per leaving member of staff. If more than one, record the one that was given as the most important. There is no requirement to provide this Data Item for individual Job Categories. However, employers such as local authorities which can provide this data for individual job roles to be encouraged to do so.
				Pay	Voluntary resignation: to get more pay
				Conditions of employment	Voluntary resignation: to get better conditions of employment
				Nature of the work	Voluntary resignation: did not like the nature of the work
				Competition from other employers	Voluntary resignation: attracted to another employer
				Career development	Voluntary resignation: move to a more senior or more challenging job, or change of career pathway
				Retirement	Including early retirement.
				Personal reasons	Voluntary resignation: for personal, family or undisclosed reasons

				Dismissal	
				Redundancy	
				Death	
				End of contract	For agency staff and temporary staff on short-term contracts.
				End of training / placement / work experience	For students
				Other reasons	Further details will be requested
				Not known	
1.12	Main destinations of staff leaving			Per categories below:	Number of staff leaving during past 12 months (Data Item 1.9). There is no requirement to provide this Data Item for individual Job Categories. However, employers such as local authorities which can provide this data for individual staff category to be encouraged to do so..
				Elsewhere in adult care sector	Employment in adult care within the UK
				Childcare or education	Working within the UK with children: childcare, early years or education.

				sector	
				Health sector	The NHS or other health-related work
				Retail / shop / supermarket work	In the UK
				Other types of employment (not care, education, health or retail)	In the UK. At present some types of care-related work e.g. probation, youth justice, community workers, housing officers would fall into this category.
				Elsewhere within the organisation	At another establishment within the same organisation
				Abroad	Including return to home country
				Other destination(s)	Further details will be requested
				Not to another job straight away	Any permanent or temporary cessation of employment. Include return to education, retirement or death. Include redundancy if it involved a break in employment.
				Not known	
1.13	Investor in			Have	

	People (IiP) status at this establishment				
				Registered / working towards	
				Not working towards	
1.14	Training needs and skill shortages			Employer assessment of training needs and skill shortages at this establishment in relation to current National Occupational Standards	Further details to follow
2	INDIVIDUAL EMPLOYEE INFORMATION				Required for all types of staff [including those in Administrative and Ancillary Job Categories] except students on placement/work experience and for volunteers [tbc].
2.1	Personal identification	2.1.1	Individual identifiers	National Insurance number	This 'unique' number is issued to an employee by the Department for Work and Pensions and is retained for life.

					Likely to be unknown for agency workers as are not directly employed. How acceptable for volunteers to be asked to provide National Insurance No.?
				GSCC Registration Number	If employee is registered with the General Social Care Council. Likely to be unknown for agency workers as are not directly employed
		2.1.2	Completion Date (Employee)	Date to which the NMDS-SC data for this employee relates.	It is envisaged that employee data can be added at an annual census date and / or at any time that it changes
		2.1.3	Post code	Employee's home post code	Post code of the employee's home address.
2.2	Job role			Using job categories and roles at Data Item 1.X	**Agency workers** to be included under the job roles they are working in. Is this feasible for local authorities?
2.3	Gender			Male	
				Female	
				Other	Current gender not necessarily the same as Sex (at birth). It is proposed that the category intersex should be used in data collection about patients

					and service users. *Should it also be included for workforce data collection?*
2.4	Date of birth				The date [day, month and year] on which the employee was born.
2.5	Ethnic group	2.5.1	White	British	The ethnic category to which the employee belongs, as determined by the individual employee Census 2001 groupings have been used here.
				Another white background	
		2.5.2	Mixed	White + Black Caribbean	
				White + Black African	
				White + Asian	
				Another mixed background	
		2.5.3	Asian or Asian British	Indian	
				Pakistani	

				Bangladeshi	
				Another Asian background	
		2.5.4	Black or black British	Caribbean	
				African	
				Another black background	
		2.5.5	Chinese		
		2.5.6	Other		Another ethnic group
2.6	Disability			Yes	Self-declared: record if employee considers him/herself to have a disability under the terms of the 1995 Disability Discrimination Act.
				No	Self-declared: record if employee considers him/herself not to have a disability under the terms of the 1995 Disability Discrimination Act.
2.7	Date started in current post			Month and year	Date (month and year) started working in current job with employer at this establishment.

2.8	Number of years worked in care sector			Years	Guidance needs to be developed on this. Comments welcome on: Whether years worked should be the grand total including any career breaks, or only the years actually worked? Whether unpaid work such as volunteering or being a carer at home (for children or older people) should be included? How wide is the range of care-related work that could be included, e.g. would probation work or work with offender/in prisons, or as housing or community worker, count? Is it realistic for local authorities / other employers to provide this information? NHS collects two 'Continuous Care Sector Service' dates, defined as: the date on which continuous service began, with no break greater than 3 months [in current job] / 12 months [in sector]
2.9	Employment status			Permanent	Employed (by the business/organisation operating at this establishment) for an unlimited duration

				Temporary	Employed (by the business/organisation operating at this establishment) for a limited duration, normally either on a fixed term contract or for a fixed task, or on a spell of casual or seasonal employment as a 'temp'.
				Agency	Supplied by an employment agency / bureau which is the actual employer.
				Student on placement / work experience	
				Volunteer	
2.10	Average hours worked per week			Contracted hours per week	Number of hours to be worked per 7 day week as stated in the employee's contract of employment.
				Average additional hours per week (outside contract)	Number of hours paid overtime usually worked per 7 day week + number of hours unpaid overtime usually worked per 7 day week (Labour Force Survey definition)
				Agreed working arrangement(s) if any: Flexitime (flexible working hours) Annualised hours	

				contract Term time working Job sharing A nine-day fortnight A four-and-a-half day week Zero hours contract None of these	
2.11	Number of days absent during past 12 months (not including leave)				The sum of all the employee's separate episodes of absence due to sickness or injury in the 12 months preceding the Completion Date (Employee) (Data Item 2.1.2) Does not include annual leave. Should compassionate leave, maternity and paternity leave be included?
2.12	Basic rate of pay			Gross annual salary OR gross hourly rate (state which)	Includes tax, National Insurance, pension contribution etc. Excludes overtime, and additions such as bonuses, golden hellos, loyalty payments etc.

2.13	Date of last CRB check			Month and year	Date (month and year) of most recent Criminal Records Bureau check.
2.14	Completed Topss England Induction Training	2.14.1	Applicability	Completed	Employee has completed Topss England Induction Training for current job at this establishment
				In progress	Employee is working on Topss England Induction Training for current job at this establishment at the Completion Date (Employee)
				Not applicable	Topss England Induction Training is not necessary/relevant for this employee in current job at this establishment.
		2.14.2	Date completed	Month and year	If 'completed' at 2.14.1: date (month and year) of completing Topss England Induction Training in current job at this establishment.
2.15	Completed Topss England Foundation Training Programme	2.15.1	Applicability	Completed	Employee has completed Topss England Foundation Training Programme for current job at this establishment

				In progress	Employee is working on Topss England Foundation Training Programme for current job at this establishment at the Completion Date (Employee)
				Not applicable	Topss England Foundation Training Programme is not necessary/relevant for this employee in current job at this establishment.
		2.15.2	Date completed	Month and year	If 'completed' at 2.15.1: date (month and year) of completing Topss England Foundation Training Programme in current job at this establishment.
2.16	Recognised qualifications achieved			Recognised qualifications	Relevant qualifications will be grouped into National Qualifications Framework Levels so that they can be mapped to the requirements for job categories. The list shown is indicative but not yet completed, and will also be subject to change as new qualifications are developed and old ones cease to be relevant.
				Health and Social Care NVQ Level 2	New awards
				Health and Social Care NVQ Level 3	
				Health and Social Care NVQ Level 4	

				Care NVQ Level 2	
				Care NVQ Level 3	
				Care NVQ Level 4	
				Caring for Children & Young People (CYPA) NVQ Level 3	
				Other care-related NVQ(s)	Including Promoting Independence Level 3, Diagnostic & Therapeutic Support Level 3, Dialysis Support; complete list tba
				Registered Manager's (Adults) NVQ Level 4	
				Registered Manager's (Children's) NVQ Level 4	
				Other management award(s)	Including Diploma in Care Services Management, Certificate in Management Studies, Diploma in Management Studies
				NVQ Assessor D32/D33/D34/D35	
				Verifier	

				Mentor	
				Social Work diploma	I.e. DipSW, CQSW, CSS
				Social Work degree	New degree, commenced September 2003 in England
				Post-Qualifying Award in Social Work (PQSW) Part 1	
				Advanced Award in Social Work (AASW)	
				Child Care Award (CCA)	Sometimes referred to as post-qualifying Child Care Award (pqCCA)
				Mental Health Social Work Award (MHSWA)	
				Practice Teacher Award (PTA)	
				Professional Occupational Therapy qualification	Degree or diploma
				LDAF	

				A Registered Nursing qualification	e.g. first/second level, RGN, RMN
				Any nursery nursing qualification	
				Any childcare, preschool or playwork qualification	e.g. CACHE, BTEC, NVQ
				Any teaching qualification	e.g. Degree, PGCE, NVQ 4; G&G 730 family
				Any basic skills, literacy & numeracy or Skills for Life qualification	
				Other relevant professional qualification	Further details will be requested
				Other qualification relevant to care sector	Further details will be requested
2.17	Date qualifications			Year each qualification held at Data Item 2.16	Achieved and awarded should normally be within the same year.

	achieved			was achieved	
2.18	Recognised qualifications working towards			As Data Item 2.16	Qualifications at Data Item 2.16 registered as working towards or studying for, if any.

APPENDIX 8: RISK LOG NMDS-SC SOLUTION

RISK LOG

Project name Skills for Care National Minimum Data Set

Release Draft 1.3

Date: 18th Jan 2006

PRINCE2

Author:	Stephanie Finch
Owner:	Francis Ward
Client:	Skills for Care
Document Number	1.3

Document Location This document is only valid on the day it was printed. The source of the document will be found in the Project File.

Revision History Date of next revision:

Revision date	Previous revision date	Summary of Changes	Changes marked
18th Jan 2006		Changes requested by Task and Finish Group on 16/1/06	Yes

Approvals This document requires the following approvals. Signed approval forms are filed in the project files.

Name	Signature	Title	Date of Issue	Version
Vic Citarella				
Francis Ward				

Distribution This document has been distributed to:

Name	Title	Date of Issue	Version
Task and Finish Group		16/1/06	1.2

The Purpose of the Register

To provide a repository of information about risks, their analysis, countermeasures and status. A risk is defined as "The chance of exposure to the adverse consequences of future events."

The management of risk is vital to the project. Work has already been done on identifying the main possible risk to the projects, allocating them an owner, and providing proposals on how the risks might be addressed. These measures can be one or more of five types

- Prevention – stopping the threat or its impact on the project
- Reduction – reducing the likelihood or its impact on the project
- Transference – passing the risk to a third party or insuring
- Contingency – actions planned to come into force when and if the risk occurs
- Acceptance – where the Board feels the risk may not occurs or countermeasures are too expensive to take.

Risk is managed by good planning, resourcing the work appropriately, monitoring progress and controlling them as far as possible.

In this Risk Log, risks are categorised according to their type – Operational, Financial, Legal, Service Delivery, Development, Environmental, HR or PR. Some risks fall into more than one category.

The Author, Date Identified, and Date Last Updated are recorded. The Likelihood or probability they will occur is evaluated. Countermeasures are listed. The Risk is

allocated an **Owner** the person best placed to monitor and manage it. The **Status** of the risk is noted "Active" – still likely to occur - or "Inactive" – danger has passed or risk has been dealt with.

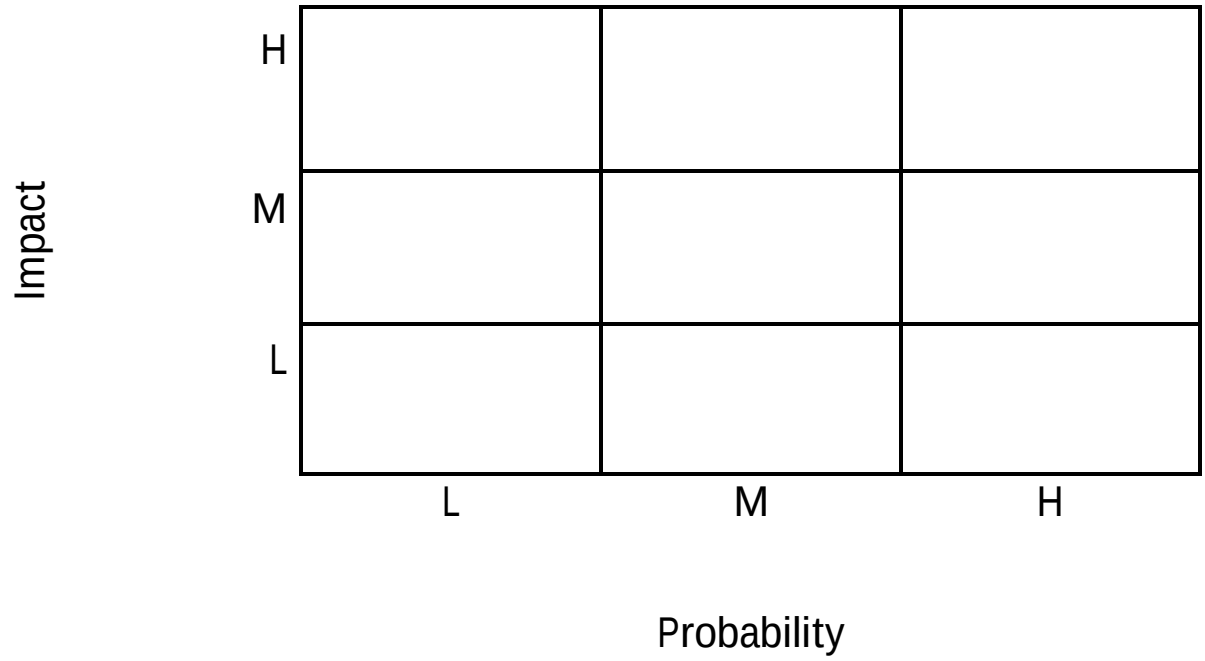
The grading of risk is as follows

- **Routine** or when a risk is being managed effectively and does not pose an immediate threat to the project
- **Urgent** or when a risk is being managed effectively but there are concerns about impact or escalation
- **Project Critical** or where a risk is recognised as being a potential 'show stopper' to the project.

The Risk Log is monitored at every meeting by the Project Delivery Group. The Delivery Group reports to the project Board through regular Highlight Reports, which will include reporting on all project critical risks and will report on other risks as they change.

Changes to the Risk Log are made by the risk owner or the Project Delivery Group or Project Board which ultimately owns it. Changes can be requested by any party for consideration firstly by the Project Delivery Group, and then recommended to the Project Board. Risk changes are not agreed until agreed by the Project Board.

Risk Categorisation



High Impact /High Probability Risks

LOG No.	DESCRIPTION OF RISK

Risks by Owner

RISK LOG	OWNER OF RISK

Risks by Risk-Type

RISK No.	Operational	Financial	Service delivery	Environmental	Development	Pr	Hr	Legal	Owner
	●					●			FW
				●					
	●	●	●			●			
		●	●		●				
	●								
	●						●		
	●	●					●		
						●			
	●	●	●	●	●				
	●	●	●	●	●	●	●		
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	●	●	●			●			
		●	●		●	●		●	
		●	●			●	●		
	●		●	●		●			
	●		●	●	●	●			

					●				
			●	●		●			
	●	●	●	●	●	●	●	●	
	●	●	●			●			
	●		●			●			
	●		●	●	●	●			
	●		●					●	
	●		●	●				●	
	●		●	●	●	●			

Risk no.	Operational	Financial	Service delivery	Environmental	Development	Pr	Hr	Legal	Owner
			●	●	●	●			
			●	●		●			
	●		●	●			●		
	●	●	●	●	●	●	●	●	
						●			
				●		●			
	●		●	●		●			
	●		●			●		●	
			●		●			●	
		●			●			●	
	●		●		●				

THE RISK LOG

Risk No.	
Type	ENVIRONMENTAL/ PR
Author	STEPHANIE FINCH
Date Identified	20/12/05
Date of Last Update	
Description	**Not achieving shared understanding of project between stakeholders and Skills for Care**
Likelihood/Probability	LOW
Severity/Impact	HIGH
Countermeasure(s)	To agree a PID setting out the parameters and tasks to be achieved. To have a transparent approach to costs to which all sides commit themselves. For the project manager to act as the key liaison point between the two parties, identifying and addressing concerns and conflicts as far as possible as they arise. To ensure the project is effectively monitored and all key tasks addressed, with problems highlighted and tackled. To implement effective consultation and communication strategies that enable key stakeholders in all organisations to own the project and have their concerns addressed.
Owner	Francis Ward
Status	ACTIVE
Grading	ROUTINE

Risk No.	
Type	ENVIRONMENTAL
Author	STEPHANIE FINCH
Date Identified	20/12/05
Date of Last Update	
Description	**Loss of commitment to the project from stakeholders and/or Skills for Care.**
Likelihood/Probability	LOW
Severity/Impact	HIGH
Countermeasure(s)	To agree and effectively monitor the PID, with problems highlighted and tackled. To agree and implement effective Communication and Consultation Strategies that achieves wide understanding and ownership among stakeholders. For stakeholders to agree the strategy formally wherever possible. To re-evaluate the project's viability if circumstances change, developing contingency plans as necessary, and making appropriate alternative funding recommendations to the Board.
Owner	Francis Ward
Status	ACTIVE
Grading	ROUTINE

Risk No.	
Type	FINANCIAL, OPERATIONAL, P.R., SERVICE DELIVERY.
Author	STEPHANIE FINCH
Date Identified	20/12/05
Date of Last Update	
Description	**Loss of political support**
Likelihood/Probability	LOW
Severity/Impact	HIGH
Countermeasure(s)	To develop and implement effective consultation and communication strategies that enable key stakeholders to own the project and have their concerns addressed. For the Project Manager to act as the key liaison point between all parties, identifying and addressing concerns and conflicts as far as possible as they arise. To agree a PID setting out the parameters and tasks to be achieved. To have a transparent approach to costs to which all sides commit themselves. To ensure the project is effectively monitored and all key tasks addressed, with problems highlighted and tackled. To have evaluated the alternatives to proceeding with the project to enable a realistic evaluation of the consequences of a failure of support.
Owner	Vic Citarella
Status	ACTIVE
Grading	ROUTINE

Risk No.	
Type	SERVICE DELIVERY, FINANCIAL, DEVELOPMENT
Author	STEPHANIE FINCH
Date Identified	20/12/05
Date of Last Update	
Description	**Legislative and policy requirements change which could impact on project.**
Likelihood/Probability	LOW
Severity/Impact	MED
Countermeasure(s)	The system will be planned as far as possible to accommodate likely future requirements. Develop sufficient flexibility within purchasing and service delivery model to adapt to change Skills for Care will seek ways to minimise the impact of changed requirements, but ultimately stakeholders would own this risk as an unavoidable cost impact, having the discretion to either address by changing requirements, or by increasing fees to cover.
Owner	Francis Ward
Status	ACTIVE
Grading	ROUTINE

Risk No.	
Type	OPERATIONAL
Author	STEPHANIE FINCH
Date Identified	20/12/05
Date of Last Update	
Description	**Cover/Support for Project Management**
Likelihood/Probability	Low
Severity/Impact	HIGH
Countermeasure(s)	To review the resourcing of the project ensuring that the project management function is clearly and effectively directed to complement the roles and skills of existing consultants, staff and Board members. To ensure that senior staff are realistically enabled to carry out work on the project in addition to their substantive roles, providing additional staff support where appropriate. To ensure that Skills for Care staff learn transferable skills from any consultants, enabling them to take more of a role when appropriate.
Owner	Francis Ward
Status	ACTIVE
Grading	URGENT

Risk No.	
Type	OPERATIONAL, HR.
Author	STEPHANIE FINCH
Date Identified	20/12/05
Date of Last Update	
Description	**Changes to key personnel in Skills for Care – including key senior staff, and consultants**
Likelihood/Probability	LOW
Severity/Impact	LOW
Countermeasure(s)	To resource senior staff to carry out their work on the project appropriately. To ensure consultants transfer learning where possible. To document the project properly in order that successors can pick up work easily. To review terms and conditions and benefits especially for senior staff, to ensure they are competitive. To carry out staff appraisals, identifying pressures and concerns and developing strategies and succession plans to address them where possible. To carry out exit interviews, identifying pressures, and the concerns of staff and potential staff - developing a strategy and succession plans to address them where possible.
Owner	Francis Ward
Status	ACTIVE
Grading	ROUTINE

Risk No.	
Type	OPERATIONAL/HR/FINANCIAL
Author	STEPHANIE FINCH
Date Identified	20/12/05
Date of Last Update	
Description	**Failure to release resources of project team within Skills for Care, to cover the project work properly in the necessary timescales.**
Likelihood/Probability	LOW
Severity/Impact	HIGH
Countermeasure(s)	To ensure a realistic appraisal of requirements, with project management to co-ordinate the overall package of work. To resource the project appropriately, providing additional resources to enable senior staff to carry out their roles, and doing everything possible to ensure continuity of senior management personnel. Project Board to agree appropriate resources and budget for project team. To ensure an effective breakdown of work into manageable work packages, with effective use of time and work scheduled realistically. To ensure consultants transfer learning where possible. To document the project properly in order that successors can pick up work easily. Where necessary to review terms and conditions and benefits for senior staff, ensuring they are competitive. To carry out staff appraisals, identifying pressures and concerns and developing strategies and succession plans to address them where possible.

Owner	Francis Ward
Status	ACTIVE
Grading	ROUTINE

Risk No.	
Type	PR
Author	STEPHANIE FINCH
Date Identified	20/12/05
Date of Last Update	
Description	**Managing press /PR poorly with an adverse impact on public support and stakeholder co-operation – especially at the trigger points of launch; inviting data submission; first publication of data analysis.**
Likelihood/Probability	LOW
Severity/Impact	HIGH
Countermeasure(s)	To develop and implement effective Communication and Consultation Strategies. To ensure the communication and, skills of key staff are evaluated and training offered as necessary. To develop an agreed policy for relations with the media. To ensure that regular information and outputs are available and that key points are planned for. To respond quickly and effectively to adverse publicity. A high quality Newsletter is distributed. Information and outputs are published regularly on the SFC Website.
Owner	Francis Ward
Status	ACTIVE
Grading	URGENT

Risk No.	9
Type	OPERATIONAL, FINANCIAL, SERVICE DELIVERY, ENVIRONMENTAL, DEVELOPMENT
Author	STEPHANIE FINCH
Date Identified	20/12/05
Date of Last Update	
Description	**Inaccurate assessment of timescales**
Likelihood/Probability	LOW
Severity/Impact	HIGH
Countermeasure(s)	To agree a realistic PID. To identify the time constraints and the impact on the project of specific immovable timescales, evaluating what can be done to minimise delay and making proposals to the Board. To work to a detailed Project Plan – agreed. To bring timely exception reports to the Board when unavoidable delays threaten. To carry out sensitivity analysis re budgetary impact and other impacts when delay threatens Risks on IT delays passed to the supplier.
Owner	Ken Messenger
Status	ACTIVE
Grading	PROJECT CRITICAL

Risk No.	10
Type	OPERATIONAL, ENVIRONMENTAL, SERVICE DELIVERY, FINANCIAL, DEVELOPMENT, PR, HR
Author	PROJECT MANAGER
Date Identified	20/12/05
Date of Last Update	
Description	**Delay to programme and project delivery date**
Likelihood/Probability	LOW
Severity/Impact	MEDIUM
Countermeasure(s)	Agree and regularly review project plan Implement change control procedure. Monitor progress against programme on regular basis. Ensure contingency plan to continue paper-based system if necessary Develop the paper-based system to accommodate other inputs if necessary.
Owner	Ken Messenger
Status	ACTIVE
Grading	PROJECT CRITICAL

Risk No.	11
Type	FINANCIAL, OPERATIONAL, P.R, SERVICE DELIVERY
Author	STEPHANIE FINCH
Date Identified	20/12/05
Date of Last Update	
Description	**Inaccuracy of financial model leads to un-anticipated costs**
Likelihood/Probability	LOW
Severity/Impact	LOW
Countermeasure(s)	To develop and sensitivity test the expected financial cost with scrutiny as required by stakeholders. To agree a comprehensive Change Control process. To develop cost effective specifications and carry out efficient tendering. To carry out regular monitoring of costs as project develops and ensure model continues to be viable. To include a sum for contingency. To negotiate a contract that sets out clear responsibility for cost increases in order that costs can be more easily predicted. To agree the outputs as far as possible in advance
Owner	TBC
Status	ACTIVE
Grading	ROUTINE

Risk No.	12
Type	FINANCIAL, OPERATIONAL, SERVICE DELIVERY, P.R.
Author	STEPHANIE FINCH
Date Identified	26.06.03
Date of Last Update	3//8/05
Description	**Funding gap – tenders are unaffordable, project costs overrun, under-funding generally**
Likelihood/Probability	LOW
Severity/Impact	HIGH
Countermeasure(s)	To agree and effectively monitor the PID, including the cost parameters with problems highlighted and tackled. To carry out a comprehensive review of requirements, in consultation with the technicians, finance staff and specialist staff. To estimate costs accurately using experience gained elsewhere. To have a transparent approach to costs to which stakeholders commit themselves. To agree a comprehensive change control procedure. To agree a fixed cost contract with the supplier in which they takes transferred risks. To monitor the development of the specification, identifying cost pressures early and options to make savings. To prioritise requirements to enable adjustments to be made if costs are too high. To re-evaluate the project's financial viability if cost change, co-ordinating the development of contingency plans as necessary, and making appropriate alternative funding recommendations to the Board. Develop the paper-based solution incrementally.

Owner	TBC
Status	ACTIVE
Grading	PROJECT CRITICAL

Risk No.	13
Type	DEVELOPMENT, FINANCIAL, LEGAL, PR, SERVICE DELIVERY
Author	STEPHANIE FINCH
Date Identified	20/12/05
Date of Last Update	
Description	**Software development is not properly controlled in terms of finances, quality, regulation and timeliness.**
Likelihood/Probability	MED
Severity/Impact	HIGH
Countermeasure(s)	To ensure specialists are consulted early in the process and advice followed Technical and other advisors to be appointed to support SFC in the negotiations For stakeholders to be involved and consulted. To agree the range of outputs needed as far as possible in advance To engage robust project management and control mechanisms. To carry out sensitivity analysis and develop contingency plans if possible. To carry out an effective tendering exercise to engage a good quality, experienced and cost effective supplier. To agree a fixed cost contract with the supplier in which they take appropriately transferred risks.
Owner	Technical advisor [TBC]
Status	ACTIVE
Grading	PROJECT CRITICAL

Risk No.	14
Type	HR, SERVICE DELIVERY, FINANCIAL, P.R.
Author	STEPHANIE FINCH
Date Identified	20/12/05
Date of Last Update	
Description	**Employment issues** **Recruitment fails to secure suitable staff to support the new system** **Retention fails and there is high turnover** **Financial cost of using agency staff** **Insufficient trained and experienced staff to support the system.**
Likelihood/Probability	LOW
Severity/Impact	LOW
Countermeasure(s)	To identify the new staffing requirements and agree the posts and funding with the SFC Board. To ensure recruitment advertising is placed in appropriate media To review terms and conditions and benefits to ensure they are competitive To carry out exit interviews, identify local market pressures, and the concerns of staff and potential staff - developing a strategy to address them where possible.
Owner	Ken Messenger
Status	ACTIVE
Grading	PROJECT CRITICAL

Risk No	15
Type	OPERATIONAL, SERVICE DELIVERY, ENVIRONMENTAL, PR
Author	Stephanie Finch
Date Identified	20/12/05
Date of Last Update	
Description	**Launch of the system goes badly, due to poor communication with stakeholders.**
Likelihood/Probability	LOW
Severity/Impact	LOW
Countermeasure(s)	Retain paper-based system until system is proven Ensure all stakeholders are identified. Ensure stakeholders receive regular updates relating to the project. Ensure that work is undertaken prior to the launch to identify links that could be of mutual benefit. To identify the current links that SFC have with stakeholders and consider ways of strengthening these. To regularly brief relevant politicians
Owner	Francis Ward
Status	ACTIVE
Grading	ROUTINE

Risk No	16
Type	OPERATIONAL, SERVICE DELIVERY, ENVIRONMENTAL, DEVELOPMENTAL, PR
Author	Stephanie Finch
Date Identified	2.9.04
Date of Last Update	3/8/05
Description	**Implementation of the software goes badly, due for example to unexpected system failures, adverse publicity, poor organization**
Likelihood/Probability	MED
Severity/Impact	HIGH
Countermeasure(s)	To develop a robust implementation Strategy. To ensure the staff are well trained and briefed. To develop and implement an effective communications and consultation strategies. To develop out good quality plans for phasing in the system and ensuring realistic appraisal of timescales and staffing requirements. Retain paper-based system until system is proven To carry out scenario planning and a dry run of the launch so that problems can be anticipated and planned for.
Owner	Ken Messenger
Status	ACTIVE
Grading	ROUTINE

Risk No.	17
Type	DEVELOPMENT, LEGAL
Author	STEPHANIE FINCH
Date Identified	20/12/05
Date of Last Update	
Description	**Design of the system is such that, even if it is constructed satisfactorily, it will not fully meet the requirements of the contract**
Likelihood/Probability	LOW
Severity/Impact	HIGH
Countermeasure(s)	To produce a careful specification of requirements and acceptance criteria To ensure good quality specialist advice is secured and followed. To transfer risks to supplier wherever possible, including this risk. Retain paper-based system until system is proven To agree a through contract outlining grounds for termination and liabilities
Owner	Ken Messenger
Grading	ACTIVE
Status	PROJECT CRITICAL

Risk No.	18
Type	SERVICE DELIVERY, ENVIRONMENTAL, PR
Author	STEPHANIE FINCH
Date Identified	20/12/05
Date of Last Update	
Description	Other elements within the social care sector may seek to undertake similar programmes or projects.
Likelihood/Probability	LOW
Severity/Impact	HIGH
Countermeasure(s)	To ensure all stakeholders involved and consulted To work with local stakeholders to ensure any similar projects are NMDS-SC compliant and can be accommodated by the national project. To seek formal mandate for the project from likely competitor organisations if at all possible, including agreement not to undertake similar projects
Owner	Francis Ward
Status	ACTIVE
Grading	ROUTINE

Risk No.	19
Type	OPERATIONAL, SERVICE DELIVERY, ENVIRONMENTAL, DEVELOPMENTAL, PR, HR, LEGAL
Author	STEPHANIE FINCH
Date Identified	20/12/05
Date of Last Update	
Description	**Non-availability – that the system goes down, does not work effectively affecting the ability of Skills for Care to collect and process data**
Likelihood/Probability	MED
Severity/Impact	HIGH
Countermeasure(s)	To ensure specialists are consulted early in the process and advice followed Technical and other advisors to be appointed to support SFC in the negotiations To engage robust project management and control mechanisms. To carry out a comprehensive review of requirements, in consultation with the technicians, finance staff and specialist staff. To produce a careful specification of requirements and acceptance criteria To develop contingency plans if possible. To carry out an effective tendering exercise to engage a good quality, experienced supplier. To agree a contract with the supplier in which they take appropriately transferred risks and penalties for non-performance. To ensure the development and implementation phase

	is effectively monitored and all problems highlighted and tackled. When system operational, to ensure all users and staff are briefed and trained on the system. To ensure service users and staff have the opportunity to pilot and test the system. To supply good quality guidance and a help desk facility
Owner	Ken Messenger
Status	ACTIVE
Grading	URGENT

Risk No.	20
Type	FINANCIAL, OPERATIONAL, SERVICE DELIVERY, PR
Author	STEPHANIE FINCH
Date Identified	20/12/05
Date of Last Update	
Description	**Changes in costs over the level allowed for in the contract.**
Likelihood/Probability	HIGH
Severity/Impact	HIGH
Countermeasure(s)	To have a transparent approach to costs to which all sides commit themselves. To agree a PID setting out the cost parameters. To estimate costs accurately using experience gained elsewhere. To monitor the development of the specification, identifying possible cost issues early and options to make savings if necessary. To prioritise requirements to enable adjustments to be made if costs are too high. To include a sum for contingency. To negotiate a contract that sets out clear responsibility for cost increases in order that costs can be more easily predicted. To agree a contract with the supplier in which they takes transferred risks including costs increases as far as possible. To ensure the contract is effectively monitored and all cost issues addressed, with problems highlighted and tackled. To re-evaluate the project/contract's financial viability if cost change, co-ordinating the development of contingency plans as necessary, and making appropriate alternative funding recommendations to the Board.

Owner	Ken Messenger
Status	ACTIVE
Grading	URGENT

Risk No.	21
Type	OPERATIONAL, SERVICE DELIVERY, PR
Author	STEPHANIE FINCH
Date Identified	20/12/05
Date of Last Update	
Description	**Obsolescence of the technology and system**
Likelihood/Probability	LOW
Severity/Impact	HIGH
Countermeasure(s)	To ensure specialists are consulted early in the process and advice followed Technical and other advisors to be appointed to support SFC in the negotiations For stakeholders to be involved and consulted. To carry out an effective tendering exercise to engage a good quality, experienced supplier. To agree a contract with the supplier in which they take appropriately transferred risks including that for obsolescence as far as possible. To agree a through contract outlining grounds for termination and liabilities
Owner	Ken Messenger
Status	INACTIVE
Grading	ROUTINE

Risk No.	22
Type	OPERATIONAL, SERVICE DELIVERY, ENVIRONMENTAL, DEVELOPMENT, P.R.
Author	STEPHANIE FINCH
Date Identified	26.06.03
Date of Last Update	3/8/05
Description	**Management of implementation of system is poorly planned, communicated or executed.**
Likelihood/Probability	LOW
Severity/Impact	HIGH
Countermeasure(s)	To develop an implementation strategy that effectively plans and manages the process To develop and implement good Communication and Consultation Strategies involving staff and stakeholders. Ensure Board is kept fully up to date and properly informed about the project at all stages To carry out through risk assessment of each stage in order to minimise problems.
Owner	Ken Messenger
Status	ACTIVE
Grading	ROUTINE

Risk No	23
Type	OPERATIONAL, SERVICE DELIVERY, LEGAL
Author	Stephanie Finch
Date Identified	20/12/05
Date of Last Update	3/8/05
Description	**Breaches of data protection and confidentiality of data**
Likelihood/Probability	LOW
Severity/Impact	MED
Countermeasure(s)	Consider and address all aspects of data protection and confidentiality with regard to system development and operation and cover liabilities in contract. Secure agreement to the use of National Insurance number - complete Plan for adequate secure storage of information. Develop contingency plans for handling adverse publicity.
Owner	Ken Messenger
Status	ACTIVE
Grading	URGENT

Risk No	24
Type	OPERATIONAL, ENVIRONMENTAL, SERVICE DELIVERY, PR
Author	Stephanie Finch
Date Identified	20/12/05
Date of Last Update	
Description	**NMDS-SC is not understood by stakeholders and response to requests for data is poor.**
Likelihood/Probability	LOW
Severity/Impact	HIGH
Countermeasure(s)	To ensure stakeholders receive regular updates relating to the project. To ensure that work is undertaken prior to going live to identify stakeholders and communicate with them To identify the current links with stakeholders and consider ways of strengthening these links. To identify hard to reach stakeholders and develop plans to make contact with them. To invite community representatives to view the building prior to opening and to the opening ceremony. To regularly brief the politicians and the media and show how data already collected is being used effectively
Owner	Francis Ward
Status	ACTIVE
Grading	ROUTINE

Risk No.	25
Type	OPERATIONAL, SERVICE DELIVERY, ENVIRONMENTAL, DEVELOPMENT, PR
Author	STEPHANIE FINCH
Date Identified	20/12/05
Date of Last Update	
Description	**Demand for the system is greater or less than predicted, both in terms of overall demand and demand for customised reports**
Likelihood/Probability	HIGH
Severity/Impact	LOW
Countermeasure(s)	To estimate demand as accurately as possible. To agree an ITT setting out the demand parameters. To prioritise requirements to enable adjustments to be made if demand is too low or high. To monitor the development of the system, identifying possible demand issues early and options to make adjustments if necessary. To include a sum for contingency. To negotiate a contract that sets out clear responsibility for demand problems order that issues can be more easily predicted. To agree a contract with the supplier in which they takes transferred risks including demand increases as far as possible. To ensure the contract is effectively monitored and all demand issues addressed, with problems highlighted and tackled. To re-evaluate the project/contract's viability if demand changes, co-ordinating the development of contingency plans as necessary, and making appropriate alternative recommendations to the Board.

Owner	Ken Messenger
Status	ACTIVE
Grading	ROUTINE

Risk No	26
Type	SERVICE DELIVERY, ENVIRONMENTAL, DEVELOPMENTAL, PR
Author	Stephanie Finch
Date Identified	16.1.04
Date of Last Update	3/8/05
Description	**Users and staff being unable to use system or finding it user-unfriendly**
Likelihood/Probability	LOW
Severity/Impact	HIGH
Countermeasure(s)	To agree an ITT, specification, and contract covering these issues. To agree an implementation strategy covering these issues. To ensure all users and staff are involved appropriately in the project development and have their needs addressed When final agreement is reached and system operational, to ensure all users and staff are briefed and trained on the system. To ensure service users and staff have the opportunity to pilot and test the system. To supply good quality guidance and a help desk facility To carry out satisfaction surveys.
Owner	Ken Messenger
Status	ACTIVE
Grading	URGENT

Risk No	27
Type	SERVICE DELIVERY, ENVIRONMENTAL, DEVELOPMENTAL, PR
Author	Stephanie Finch
Date Identified	20/1205
Date of Last Update	
Description	**Users do not migrate as expected to the web-based system from the other forms of data submission.**
Likelihood/Probability	MED
Severity/Impact	MED
Countermeasure(s)	To agree an implementation strategy covering these issues. To carry out satisfaction surveys and agree contractual responsibilities with the supplier for responding to obstacles. To consult users to identify problems early. To ensure ongoing availability of other services if required. Provide incentives to encourage migration.
Owner	Ken Messenger
Status	ACTIVE
Grading	URGENT

Risk No	28
Type	OPERATIONAL, SERVICE DELIVERY, ENVIRONMENTAL, HR
Author	Stephanie Finch
Date Identified	
Date of Last Update	
Description	**Skills for Care's being inexperienced in managing data collection and analysis, and failing to provide a suitable service.**
Likelihood/Probability	MEDIUM
Severity/Impact	HIGH
Countermeasure(s)	To identify and plan for the provision of suitable specialist advice To ensure suitability of contractor selected to provide the service.. To identify and plan for the provision of suitably qualified staffing To have robust systems in place for communication, and staff consultation and support. To create learning and development materials for staff to highlight the required standards. To agree plans covering such internal HR and organisational issues. To liaise with stakeholders and ensure all requirements with regard to all aspects of operating the system have been addressed. To have robust system in place for supporting the contracts management and monitoring
Owner	Francis Ward
Status	ACTIVE
Grading	URGENT

Risk No.	29
Type	OPERATIONAL, FINANCIAL, ENVIRONMENTAL, P.R., DEVELOPMENT, SERVICE DELIVERY, HR, LEGAL.
Author	STEPHANIE FINCH
Date Identified	26.06.03
Date of Last Update	23/1/04
Description	**Failure of project**
Likelihood/Probability	LOW
Severity/Impact	HIGH
Countermeasure(s)	Depending on why the project has failed, for Skills for Care to evaluate alternatives and possible contingency plans. To re-evaluate the project's viability if circumstances change, developing contingency plans as necessary, and making appropriate alternative funding recommendations to the Board.
Owner	Francis Ward
Status	ACTIVE
Grading	ROUTINE

Risk No.	30
Type	P.R.
Author	STEPHANIE FINCH
Date Identified	20/12/05
Date of Last Update	
Description	**Future reputation of SFC is damaged by project failure.**
Likelihood/Probability	LOW
Severity/Impact	MEDIUM
Countermeasure(s)	For the Project Manager to act as the key liaison point between all parties, identifying and addressing concerns and conflicts as far as possible as they arise. To develop and implement effective Communication and Consultation Strategies. Strategies developed. To ensure the communication and media skills of key staff are evaluated and trained. Achieved. To respond quickly and effectively to adverse publicity – using press resources as appropriate To agree a PID setting out the parameters and tasks to be achieved, ensuring the project is effectively monitored and all key tasks addressed, with problems highlighted and tackled. . To re-evaluate the project's viability if circumstances change, developing contingency plans as necessary, and making appropriate alternative funding recommendations to the Board. To develop contingency plans, including a paper-based system in order that data collection is not solely dependent on the software. Ensure Board is kept fully up to date and properly informed about the project at all stages.

Owner	Francis Ward
Status	ACTIVE
Grading	ROUTINE

Risk No.	31
Type	ENVIRONMENTAL, PR
Author	STEPHANIE FINCH
Date Identified	20/12/05
Date of Last Update	
Description	**The programme is seen as a panacea for all social care data collection issues, with the result that issues not addressed through NMDS-SC are ignored and negative fall-out as a result affects the image of the NMDS-SC.**
Likelihood/Probability	LOW
Severity/Impact	LOW
Countermeasure(s)	All publicity material clearly sets out the remit of the system Stakeholders are made aware of the issues the system will not address and why The achievements of the system are well publicised to counter any possible disappointment. Regular outputs and information available
Owner	Francis Ward
Status	ACTIVE
Grading	ROUTINE

Risk No.	32
Type	OPERATIONAL, SERVICE DELIVERY, ENVIRONMENTAL, PR,
Author	STEPHANIE FINCH
Date Identified	20/12/05
Date of Last Update	
Description	**Data protection concerns may affect the willingness of stakeholders to participate and supply data.**
Likelihood/Probability	MOD
Severity/Impact	HIGH
Countermeasure(s)	Consider and address all aspects of data protection and confidentiality with regard to system development and operation and cover liabilities in contract. Secure agreement to the use of National Insurance number - complete Plan for adequate secure storage of information. Communicate widely with stakeholders and provide publicity material that addresses such concerns Develop contingency plans for handling adverse publicity.
Owner	Francis Ward
Status	ACTIVE
Grading	URGENT

Risk No.	33
Type	OPERATIONAL, SERVICE DELIVERY, PR, LEGAL
Author	STEPHANIE FINCH
Date Identified	20/12/05
Date of Last Update	
Description	**Data security is compromised by unauthorised access [hacking]**
Likelihood/Probability	MOD
Severity/Impact	HIGH
Countermeasure(s)	Consider and address all aspects of data protection and security with regard to system development and operation, ensuring appropriate levels of protection such as firewalls, and cover liabilities in contract. Plan for adequate secure storage of information. Develop contingency plans for addressing incidents, including the involvement of the police and adjustments to the system. Develop contingency plans for handling adverse publicity.
Owner	Ken Messenger
Status	ACTIVE
Grading	URGENT

Risk No.	34
Type	DEVELOPMENT, SERVICE DELIVERY, LEGAL
Author	STEPHANIE FINCH
Date Identified	20/12/05
Date of Last Update	
Description	**Design of the system is such that, even if it is constructed satisfactorily, it will not fully meet the requirements because the design cannot adapt to changes in legislation**
Likelihood/Probability	
Severity/Impact	
Countermeasure(s)	The system will be planned as far as possible to accommodate likely future requirements. Develop sufficient flexibility within purchasing and service delivery model to adapt to change Skills for Care will seek ways to minimise the impact of changed requirements, but ultimately stakeholders would own this risk as an unavoidable cost impact, having the discretion to either address by changing requirements, or by increasing fees to cover. To ensure Board is kept fully up to date and properly informed about the project at all stages
Owner	Ken Messenger
Status	ACTIVE
Grading	URGENT

Risk No.	35
Type	FINANCIAL, DEVELOPMENT, LEGAL
Author	STEPHANIE FINCH
Date Identified	20/12/05
Date of Last Update	
Description	**Design of the system is such that, even if it is constructed satisfactorily, it will not fully meet the requirements of the contract in terms of the costs of maintenance and running cost.**
Likelihood/Probability	MOD
Severity/Impact	HIGH
Countermeasure(s)	To develop and sensitivity test the expected costs. To agree a comprehensive Change Control process. To develop cost effective and realistic specifications and carry out efficient tendering. To carry out regular monitoring of costs as project develops and ensure model continues to be viable. To include a sum for contingency. To negotiate a contract that sets out clear responsibility for cost increases in order that the risk of such cost increases are transferred where possible to the supplier.
Owner	TBC
Status	ACTIVE
Grading	URGENT

Risk No.	36
Type	OPERATIONAL, DEVELOPMENT
Author	STEPHANIE FINCH
Date Identified	18/1/06
Date of Last Update	
Description	**Detrimental impact on this project from the pressure on Skills for Care to manage this and the project to develop the Phase 1 System for the LRC simultaneously.**
Likelihood/Probability	MOD
Severity/Impact	MOD
Countermeasure(s)	To manage both project through Prince2 to ensure thorough resource planning, control and management of risks For both projects to report through their Project Boards to the Skills for Care Board to ensure equitable allocation of resources and management of any conflicts For both projects to maximise mutual learning and take advantage of common areas for documentation and collaboration For both projects to use external advice carefully to cover areas of pressure and scarce expertise
Owner	TBC
Status	ACTIVE
Grading	URGENT

Risk No.	37
Type	OPERATIONAL, SERVICE DELIVERY, DEVELOPMENT
Author	STEPHANIE FINCH
Date Identified	18/1/06
Date of Last Update	
Description	
Likelihood/Probability	MOD
Severity/Impact	MOD
Countermeasure(s)	To manage both project through Prince2 to ensure thorough resource planning, control and management of risks For both projects to report through their Project Boards to the Skills for Care Board to ensure equitable allocation of resources and management of any conflicts For both projects to maximise mutual learning and take advantage of common areas for documentation and collaboration For both projects to use external advice carefully to cover areas of pressure and scarce expertise
Owner	TBC
Status	ACTIVE
Grading	URGENT

APPENDIX 9: SUPERMARKET THINKING

The analogy of supermarket/shop---------- social care

Why supermarkets do better than corner shops – Excluding price issues.

- Give people what they want - a quality product –(social care service)
- Understand what they want - market research (ask them- the service users)
- Know what we can provide (know your staff group/resources- training levels and skills mix)
- Know when to provide it (make sure you know when key times are - demand - Xmas/ call centre moves in to town)
- Make sure it's available (recognise what's missing – know what you need/what you have now/ what's gone)
- Never let what's required be out of stock (make sure you recruit well to deliver)
- Train people to know (good HR management skills)
- Soup-prefer-need-make it available (understand skill mix/ understand HR stock)
- Make sure people know what's required (2)- ask service users
- Make sure you have what they want (the right staff)
- Know when you need to improve your stock (train/recruit)
- Understand what changes in the seasons- BBQ food/ outdoor food in the summer- not the winter - know when and what causes changes in your staff group… be prepared for call centres/ staff turnover/ know what keeps staff in place

APPENDIX 10: DRAFT FAQ FOR THE NMDS-SC

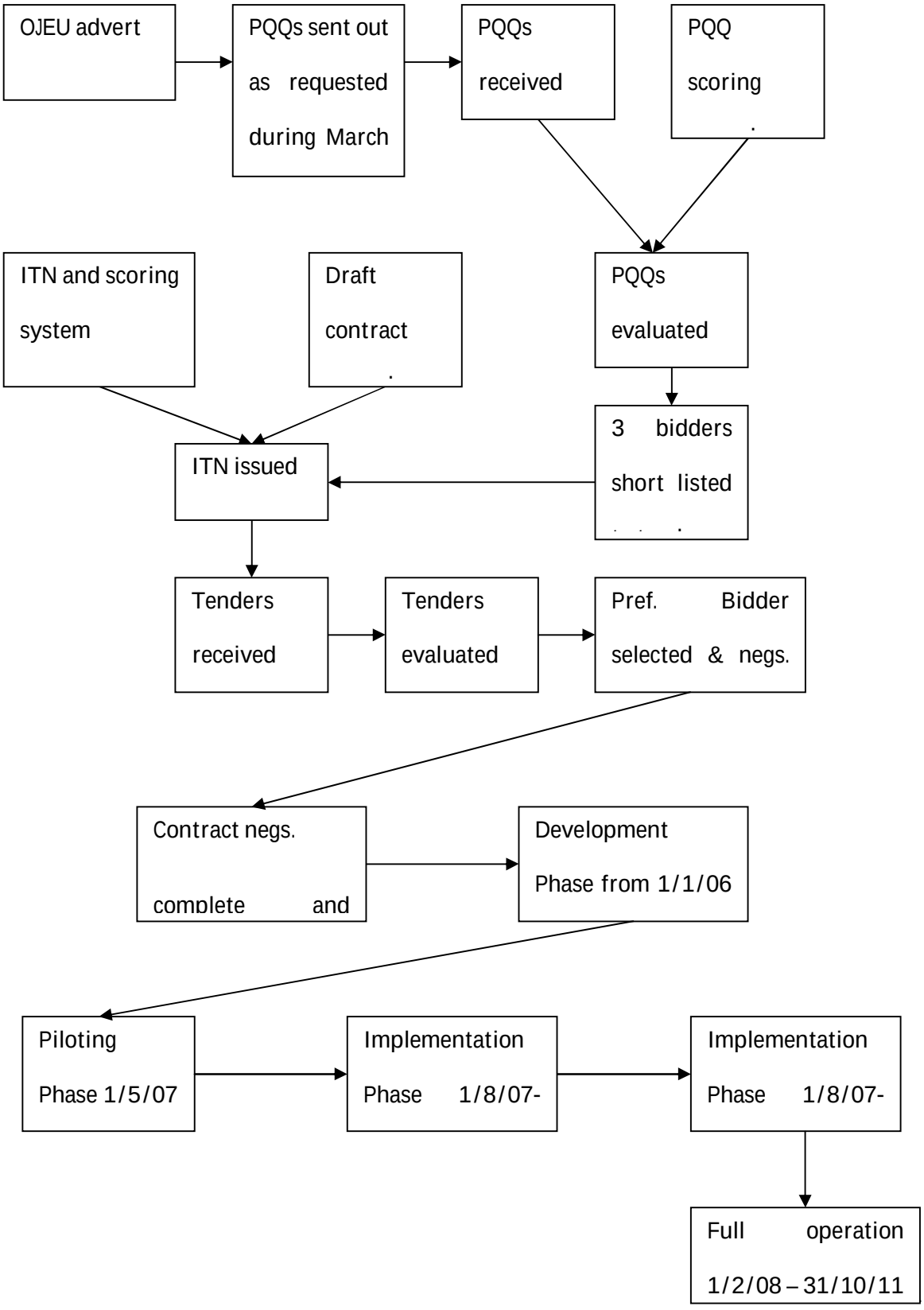
What	**What is the NMDS-SC?**	The NMDS-SC is the first attempt to gather workforce information for the social care sector. The NMDS-SC is a means of gathering a minimum of information about services and staff across all service user groups and sectors within social care. The information will be used, confidentially, to make policy decisions on how to support employers and staff in delivering quality services.
Why	**What happens to my information?**	The information, which you supply, will be sent directly to Skills for Care. It will then be entered into an information database where it will be anonymised. It will be used by Skills for Care to develop reports and statistics about the social care workforce. It will be held securely by us, no one else will see this information unless you give us permission to share some of the information with the Skills for Care regions and CSCI.
	Why do you need the National Insurance numbers of my staff?	It is important to us to count people only once. The NINO helps us do this by using the NINO and the employee's date of birth we can be confident that they only appear once in the national statistics. We do not use the NINO for any other reason. The NINO is used by Skills for Care only. It will not be shared with any other agency or person.
	Will the information be shared with the local authority?	No. Local Authorities are also being asked to provide the information for their services and staff. They will not be able to identify your business from the statistics. We will provide reports to Local Authorities because they are involved in commissioning services and need

		to take a strategic overview of services in their area. These reports will be statistical in nature. They will be anonymous.
	Why do you need information about pay?	One of the main issues raised by employers is the lack of funding to support services. Information about pay enables us to do a number of things: It will enable us to report on the real cost of care. It will enable us to develop strategies to help the sector with recruitment and retention issues. It will enable us to define career pathways for people interested in working in social care. It will give us a national and regional picture of pay differences. The information about pay will be held securely by Skills for Care and will not be shared with any other agency. No one will be able to identify your business and the money you spend on pay. We will anonymise information about pay.
	Why should I complete the NMDS-SC? **I already have a staff record system and filling in the NMDS-SC electronically or on paper means I will duplicate information I already have.**	True. Many organisations and businesses already have their own staff record system. It is unlikely that your system gathers all of the information that is in the NMDS-SC. We are developing systems to gather the information that will enable employers who do have a staff record system to electronically download or copy information into the NMDS-SC. This will enable us to anonymised your information and use it to provide reports to influence policy development and funding assistance for staff development. One of the standard reports that you can use from your information may be used as a report for CSCI about

		your staff development responsibilities. Some organisations/businesses have already indicated that they will use the NMDS-SC as their staff development system.
Who	**Who should complete the NMDS-SC?**	As the Sector Skills Council for Social Care, we would encourage all employers working in social care to complete the NMDS-SC. With a full picture of the qualification and learning needs we will be able to develop strategies to target scarce resources to where they have the most need and impact. The information will enable us to have a full picture of the issues facing the social care sector and enable us to support the development of a first class workforce providing first class services to people who use social care services.
When	**When should I complete the NMDS-SC?**	Now. You can get paper copies of the NMDS-SC from your regional committee for Skills for Care. You can also complete the NMDS-SC electronically; the regional committee will have the means to support you in doing this.
	Do I need to complete it more than once?	No. Once we have your information there will only be a need to update or check your information for accuracy once a year. Some employers might want to use the electronic version of the NMDS-SC as their staff training record and update their staff records on a regular basis.
Help	**Where can I get help to complete the NMDS-SC?**	There different strategies being developed across the regions of England to assist and help you complete the NMDS-SC. Your local contact is: refer to contact sheet.
	I don't have a computer: how	We are providing paper copies of the NMDS-SC-this is

	do I complete the NMDS-SC?	like a questionnaire. With the NMDS-SC we also provide a help booklet that explains each of the questions in more detail if this is the help you need.

APPENDIX 11: FLOW DIAGRAM FOR THE NMDS-SC ONLINE BUILD



APPENDIX 12: WHAT'S IN IT FOR ME? DRAFTS

What's in it for me documents first draft October 2006

Local Authorities

Completing the information asked for in the NMDS-SC will enable your organisation to:

- Identify staff skills, needs and achievements.
- Create a staff development and training plan that meets the needs of the organisation and which reflects the National Minimum Standards.
- Effective workforce planning for your current and future social care workforce.
- Personal development planning for individual staff.
- Identify recruitment and retention issues and enable you to develop succession-planning strategies.
- Ability to develop staff skills and competence in line with regulation and good social care practice.
- Access to local and regional supported learning.
- Ability to target government funding against specific outcomes.
- Provide anonymous information for Skills for Care to represent the social care sector and to attract resources to support the social care skills agenda.
- Labour Market Information to assist in the strategic planning and the future needs of service user groups.
- Benchmark your services with other organisations.

Social Care Employees

We are asking all social care workers to complete a national survey of the workforce. In each region of England Skills for Care has developed a Regional Committee to assist and overview learning support for social care workers. By providing information about yourself, your area of work, your skills needs, current employment and current service user specialism we hope to be able to support your qualification and development in social care. This will enable you to:

- Access funding to support your personal skills development.
- Access advice, guidance and information that will enable you to make the right choices of learning and career progression.
- Your information will enable us to predict the level of resources needed to support employment and learning in your region.
- Your information will enable us, as your Sector Skills Council, to represent the social care sector in regional and national policy decisions.

Social Care Employer

Completing the information asked for in the NMDS-SC will enable you and your business/organisation to access the following benefits:

- Identify staff skills needs and achievements.
- Develop a staff development and training plan.
- Effective workforce planning for your current social care practice.
- Identify skill shortages.

- Personal development planning for individuals.
- Ability to develop staff skills and competence in line with regulation and good business practice.
- Access to local and regional supported learning.
- Provide anonymous information for Skills for Care to represent the social care sector and to attract resources to support the social care skills agenda.
- Enable your business/organisation to be recognised by the different strategic and funding agencies in your region when they consider the economic support strategies available in your locality.

A fully populated dataset for the Social Care Sector will enable the Regional Committee of Skills for Care to:

- Use Effective Labour Market Information to assist in the strategic planning to meet the future needs of the local and regional social care economy.
- Develop a strategic economic plan with key stakeholders in the social care sector.
- Ensure funding targets and funding opportunities meet the needs of the social care sector.
- Predict demand and supply chain issues and address the issue of access to Learning opportunities and to ensure that there is a sufficient capacity to meet the demand.
- Ability to 'measure' outcomes in relation to the regional and local economy.
- Ability to predict labour market trends and the need for business development and support for the social care sector employers.

A fully populated dataset for the Social Care Sector will enable Learning and Skills Councils to:

- Use 'hard data' to inform the Strategic Area Review processes.
- Ensure funding targets are commensurate with sector needs.
- Predict 'uptake' of particular levels of qualification.
- Predict the 'skills for life' needs in the social care industry.
- Predict demand and supply chain issues.
- Align capacity and development needs.
- Develop a three-year strategic plan with key stakeholders in the social care sector and education industry.
- Labour Market Information to assist in the strategic planning and the future needs of the local economy.
- Ability to 'measure' learning outcomes in the social care sector against LSC funded targets.
- Ability to target LSC resources to achieve best practice in learning and education for the social care sector

Part of the Sector Skills Council
Skills for Care and Development

nmds-sc™
national minimum
data set for social care

Local Learning Skills Councils

What's in it for me?

A fully populated dataset for the Social Care Sector will enable LSC's to:

- Use 'hard data' to inform the Strategic Area Review processes.
- Ensure funding targets are commensurate with sector needs.
- Predict 'uptake' of particular levels of qualification.
- Predict the 'skills for life' needs in the social care industry.
- Predict demand and supply chain issues.
- Align capacity and development needs.
- Develop a three-year strategic plan with key stakeholders in the social care sector and education industry.
- Labour Market Information to assist in the strategic planning and the future needs of the local economy.
- Ability to 'measure' learning outcomes in the social care sector against LSC funded targets.
- Ability to target LSC resources to achieve best practice in learning and education for the social care sector.

Business Network and Regional Development Agencies

- Effective Labour Market Information to assist in the strategic planning and the future needs of the local and regional economy.
- Develop a strategic economic plan with key stakeholders in the social care sector.
- Ensure funding targets and funding opportunities are commensurate with sector needs.
- Predict demand and supply chain issues are aligned and capacity issues are addressed.
- Ability to 'measure' outcomes in relation to the regional and local economy.
- Ability to predict labour market trends and the need for business development and support for the social care sector employers.

APPENDIX 13: BOARD AND GROUP MEMBERSHIP

Membership from Social Care & Health Workforce Group to Skills for Care WF Intelligence Board including WFI Technical group. Excluding FW.

	Organisation Represented	Original SC+H WFG 2000-2003	LA WIG	Topss England T&F WFIG 2003-2005	SFC WFI Board 2005-2008	SfC WFI Technical group 2005-2008
Vic Citarella- chair	SfC Board – LGA		×	×	×	
Lional Took	DH	×			×	
Anne Mercer	DH				×	
Frank Ursell	RNHA	×		×	×	
Jill Manthoprpe/ Peter Huxley	SCWFU KCL			×	×	
David Leay/ Keith Brumfit (from 2005)	CWDC				×	×
Nigel Dua	Federation of Small Businesses				×	
Andre Rowe	CEO SfC	×		×		
Francis Ward	SfC	×		×	×	
Andrew Cooper	DEfC				×	
John Barker	GSCC			×	×	×
Owen Davies	Unison-	×			×	

Amanda Edwards	SCIE-				×	
Eric D'Ath	CVS			×		
Sheila Scott	National Care Association	×			×	
David Mellor	Employers Organisation	×		×	×	×
Jane Winter	NHS Confederations/WDP			×	×	
Erica De'Ath	Childrens soc?			×		
Mark Dunn	EO		×			×
Ben Hickman	EO		×			×
Kate Crofts	EO		×			
Christine Eborall	SfC			×	×	×
Ken Messenger	SfC			×		×
Keith Childs	DH	×		×		×
Christine Burket	?					
Melanie Newman	DH			×		
Guy Cross	NHS			×	×	
Bill McLimont	SfC board	×		×		
Trish Davis	NCSC			×		

Lesley Rimmer	UKHCA			×	×	
Avril Hobson	London NHS confederation			×		
Kunku Suta	Warwickshire LG		×			
Peter Mathias	City and Guilds - awarding body			×		
Alan Skelt	Edexcel - awarding body			×		
Mike Beazley/ Trish Davies	CSCI	X		X		

APPENDIX 14: NMDS-SC ONLINE REPORTING

Below is a list of key 'customer-facing' reports that are to be available from NMDS-SC Online to employers and Regional Leads at the initial go-live releases in August and November 2007. Further reports (see Section C below) will be available in the third and final release in April 2008 when the full NDMS-SC Online reporting capability is delivered.

In addition to standard reports listed in this document, which will be automatically generated and made available via NMDS-SC Online, the SRI Workforce Intelligence Team will have the capability to create ad-hoc reports on demand.

With the exception of Analytical Files, which will be provided in an SPSS-compatible CSV file format, all standard report will be provided in Excel, PDF and on-screen (i.e. print directly from browser) file formats.

A. Reports available in August 2007 release

1. Worker Report

Frequency: Latest data on request (requires update by user)

Recipient: NMDS-SC respondent

Description: The Worker report consists of two sub-reports:

Worker List: a report that provides data on all workers at the establishment. Data include internal identifier, date of birth, NINO, NMDS-SC ID, and main job role.

Worker Details: a report that provides full details for an employee at the establishment, including gender, age ethnicity, job roles, employment status, pay, qualifications etc.

2. Establishment Profile

Frequency: Latest data on request; regional comparison with last month's snapshot regional data (requires update by user)

Recipient: NMDS-SC respondent; and (if permissions given by NMDS-SC respondent) parent respondent and Regional Lead

Description: The Establishment report provides a profile of the establishment's workforce compared to similar establishments within the same region. Data include address details, parent establishment (if applicable), NMDS-SC Number, last completion date of NMDS-SC data, establishment CSCI/Ofsted status, establishment IIP status etc.

Comment: Depending on the size of the relevant profile, this report may not be suitable for PDF file format.

3. NMDS-SC Management Information Report

Frequency: Monthly

Recipient: SfC NMDS-SC Project Team

Description: The monthly MI report is intended to provide the project team with information on the usage of the NMDS-SC Online system, and includes year-to-date analysis, trends and comparisons with previous year. The report will include data on levels of new NMDS-SC returns and dates of completion, overall numbers of records, numbers of updates etc.

4. Analytical Files

Frequency: Latest data on request

Recipient: SfC NMDS-SC Project Team

Description: The monthly MI report is intended to provide the project team with information on the usage of the NMDS-SC Online system, and includes year-to-date analysis, trends and comparisons with previous year. The report will include data on levels of new NMDS-SC returns and dates of completion, overall numbers of records, numbers of updates etc.

B. Reports available in November 2007

1. CSSR Geographical Profile

Frequency: Monthly

Recipient: All logged-in NMDS-SC users

Description: The CSSR (Councils with Social Services Responsibilities) Profile intends to provide public, voluntary and statutory sector providers with an overview of the care infrastructure and workforce in a CSSR geographical area. The analysis of aggregated data includes comparison of numbers and types of establishments, workforce demographics, pay, qualifications, organisational size and the nature of services provided.

2. Regional Leads Report

Frequency: Weekly

Recipient: SfC Regional Lead

Description: The Regional Leads report provides weekly statistics on the number of new NMDS-SC establishment records and updates to existing records for each region. The information includes weekly, monthly and year-to-date totals as well as comparison with other regions' and national data. A complete list of the establishments that have been added and updated over the last four weeks is provided.

3. RDM Report

Frequency: Weekly

Recipient: SfC Regional Development Manager

Description: The weekly RDM report is a simplified version of the more comprehensive Regional Leads Report (see above), excluding the detailed establishment list.

C. Reports available in April 2008

The reports listed below have been defined as standard reports required for the April 2008 release of NMDS-SC Online; the detailed composition and structure of these reports is subject to further development.

- Large Employer's Report
- Local Authority Report
- Regional Report
- National Report
- Annual Workforce Planning Report
- Staff Training and Development Report

APPENDIX 15: PROMOTIONAL DVD

The original promotional DVD on the NMDS-SC including Liam Byrne Government Minister DH + Key stakeholders

Liam Byrne - Minister for Social Care, DH

Nigel Dua - National care spokesman for the Federation of Small Businesses

Jane Winter - Assistant Director, Social Care: North East London NHS

Adam Cooper - Workforce Planning and Strategy Team, Children's Workforce Unit, DfES

Frank Ursell – CEO, Registered Nursing Home Association

David Leay - Children's Workforce Development Council

Rachel Charlton – Director, National Workforce Projects, NHS

Vic Citarella - Chair of SfC Workforce Intelligence Board and LGA member of SfC board

Francis Ward - Head of Skills, Research and Intelligence. SfC

Professor Jill Manthorpe - Joint Head of Social Care Workforce Research Unit KCL

Andrea Rowe - CEO SfC

David Mellor – Employers' Organisation for Local Government

Sheila Barrett - Practice Development Manager SCIE

The Wanless Team

Julie Edwards - Hertfordshire Council

Jonathon Phillips - Director of Quality performance and Methods, CSCI

Jenifer Bernard - Consulting Director, C&G

Heather Wing - Director of Regulation, GSCC

APPENDIX 16: HOW TO USE THE NMDS-SC ONLINE VIDEO

SfC online promotional video: How to complete the NMDS-SC (2007)

APPENDIX 17: TOPSS ENGLAND H&SC DATA TRAWL

Attempting to find sources of data among the Health & Social Care Work Force Group members 2002-3

Topss Workforce Intelligence group

This is an initial first cast trawl to discover social care work force data collection details amongst the range of organisations currently represented in the group. None were ever returned.

Name/Organisation(s)	
What data is collected and why.	
How is it used.	
What format is it stored in.	
Is the data available to access by others-Who	
Are there any data protection issues with collection of this data.	
Where is the exact location of this data now. Give contact person details. What data collection is planned for the future.	
Identify any gaps in data you are aware of.	
How might Topss improve these gaps.	
Why do you think this missing data is needed?	

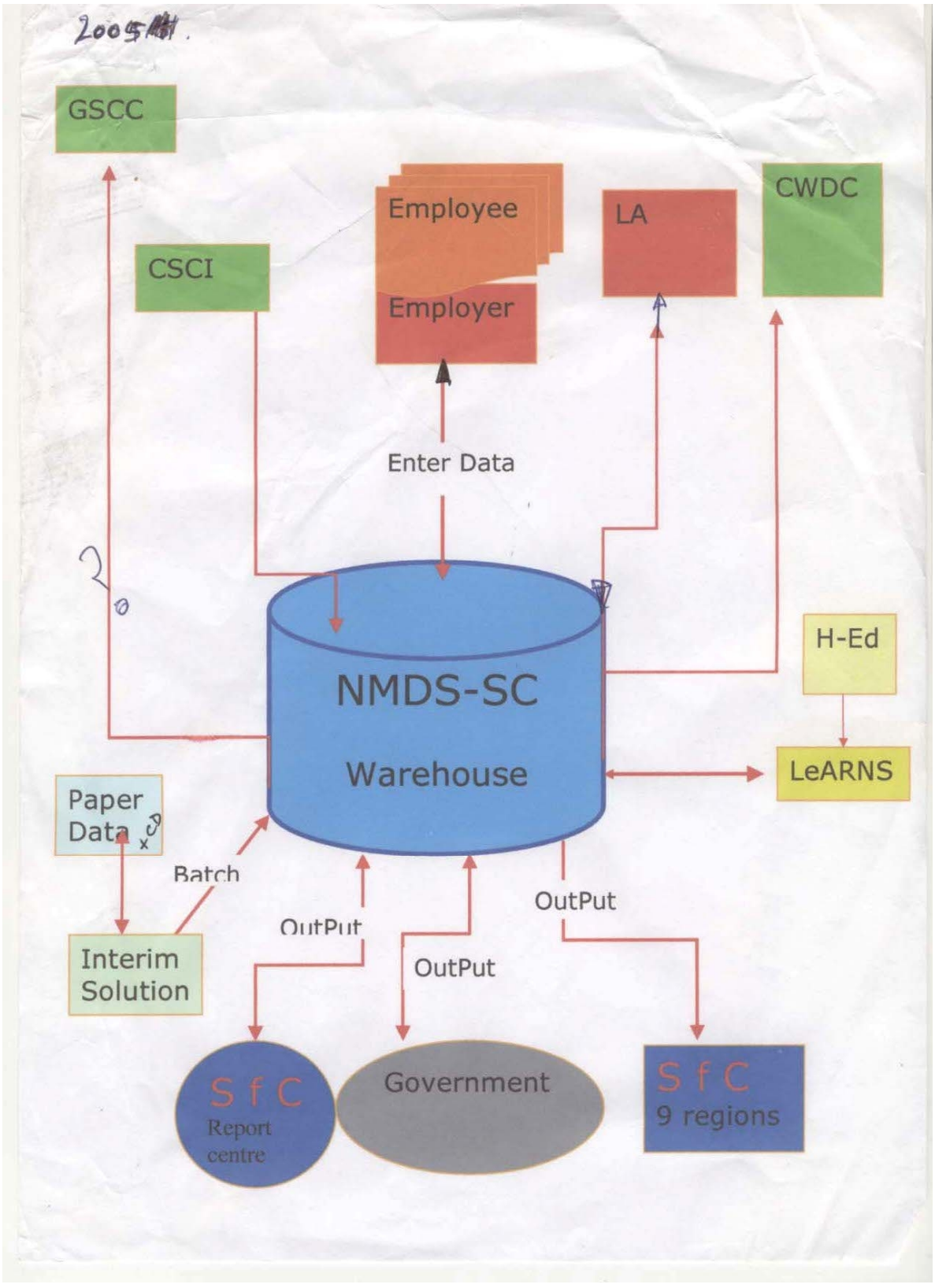
What analysis might be required of this data	

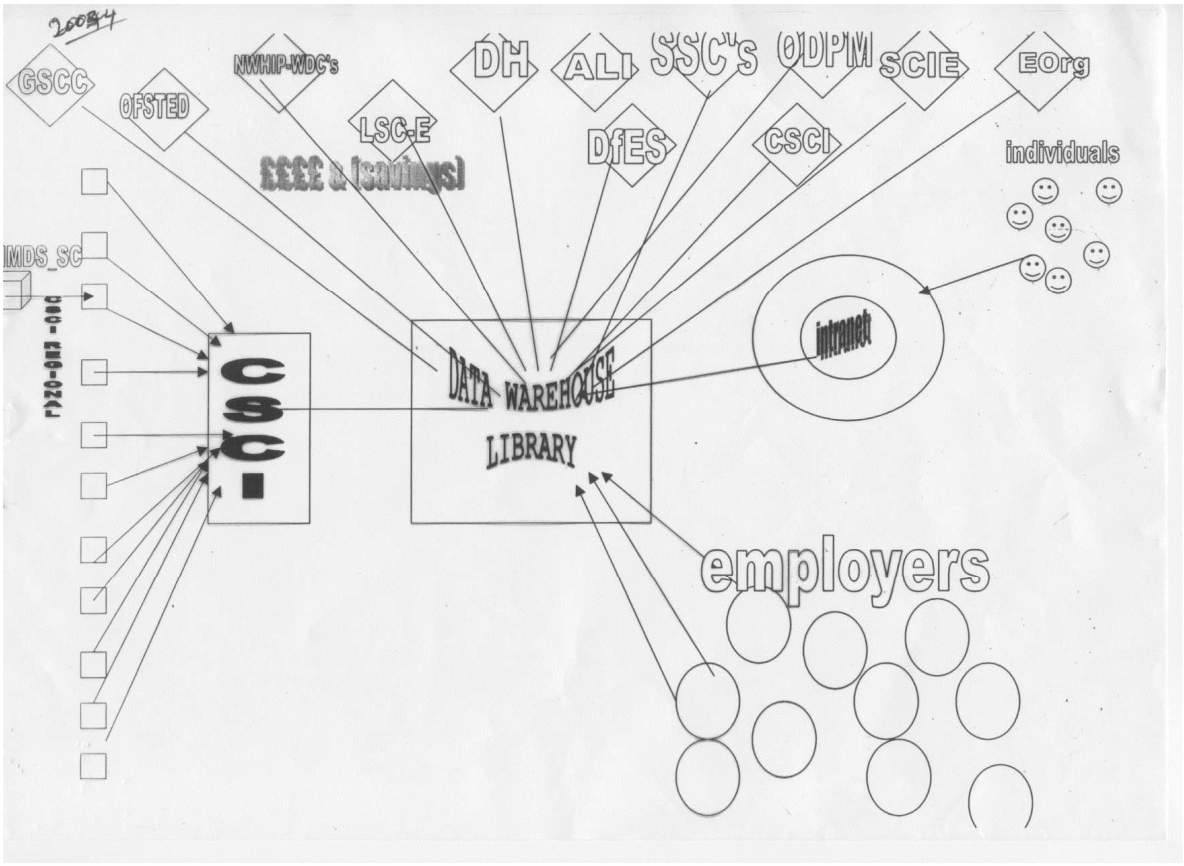
Please return completed forms to Francis Ward or Kate Sheehan at Topss.

An electronic version of this form will be sent out on e mail.

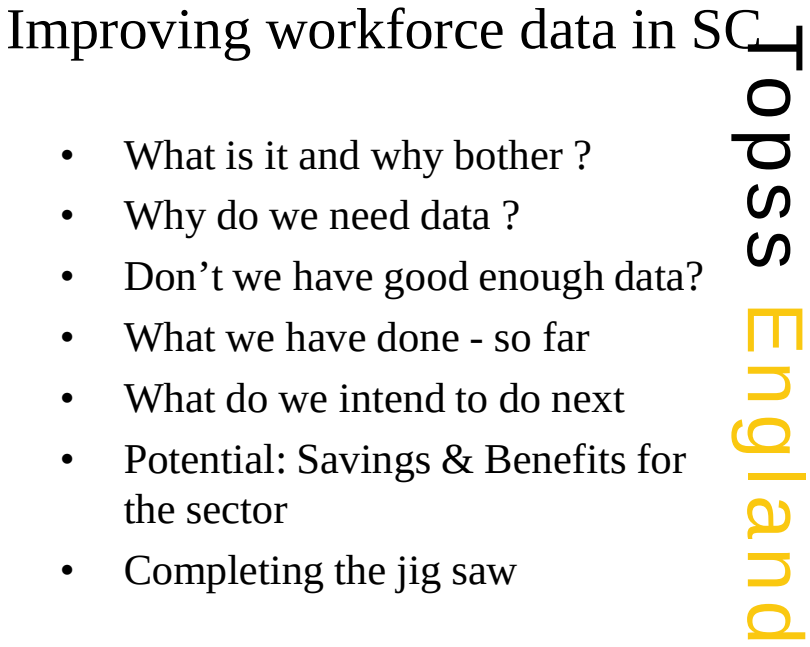
APPENDIX 18: EARLY CONCEPT NMDS-SC DIAGRAMS

2 early prototype plans of how the NMDS-SC online might operate

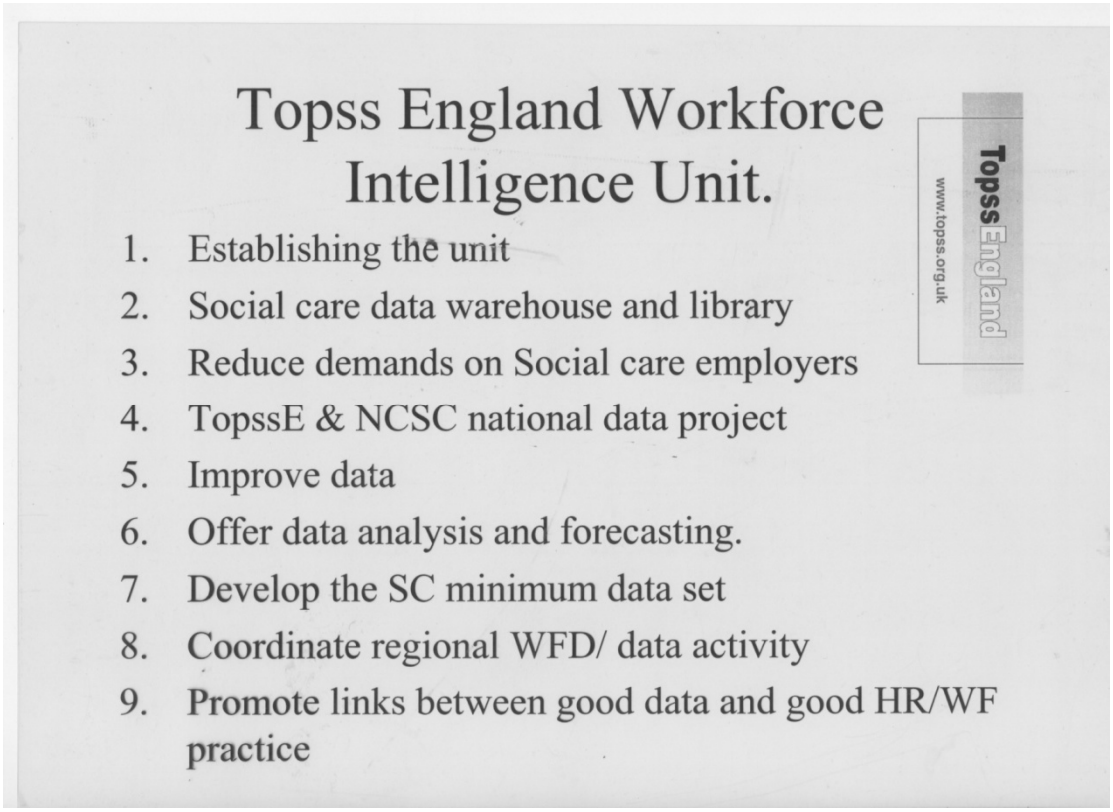

GSCC
CSCI
Employee
Employer
LA
CWDC
Enter Data
NMDS-SC
Warehouse
H-Ed
LeARNS
Paper Data
Batch
Interim Solution
OutPut
OutPut
OutPut
S f C
Report centre
Government
S f C
9 regions


GSCC
OFSTED
NWHIP-WDC's
LSC-E
DH
ALI
SSC's
ODPM
SCIE
EOrg
DfES
CSCI
individuals
IMDS_SC
CSCI
DATA WAREHOUSE
LIBRARY
intranet
employers

APPENDIX 19: REGIONAL/NATIONAL TALKS ON GETTING BETTER WORKFORCE DATA, 2003-04



My agenda for the WFIU as part of a presentation to a national conference circa 2004



APPENDIX 20: NMDS-SC ONLINE FRONT PAGE, 2010